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AUTONOMY AND MIDWIFERY

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Master of Philosophy

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ABSTRACT

Autonomy is a concept central to the definition of a midwife: “the midwife is an autonomous practitioner of midwifery, accountable for the care she or he provides” (WHO 1992, P3). However, as a concept, the term ‘autonomy’ is very complex and the degree that midwives are able to demonstrate their autonomy when making decisions in the clinical setting is variable and depends on the extent of authority given to them by their place of practice as well as their own personal willingness to accept such freedom. This study looks at the nature of autonomy within the midwifery profession, the impetus for which, arose from my passion for the art and science of midwifery over the past sixteen years and my constant questioning of the real possibility of autonomous midwifery practice or more specifically of the parameters and limitations entailed with autonomy and how this impacts on midwifery care.

The aims of the study were fourfold:

1. To explore and interrogate the nursing, midwifery and medical literature on aspects of autonomous practice.
2. To explore midwives views on the concept of autonomy.
3. To identify factors that might influence autonomy within practice.
4. To explore the effect of different working environments on midwives’ autonomy.

Methodology

Critical reviews of the literature: The literature reviews, which were confined to a maximum of seven of the more widely, read journals, covering the past twenty years, included:

- The scope of midwives’ practice and how this affects autonomy
- The impact of supervision on autonomy and freedom of practice
- The link between accountability and autonomy within a litigious society.

Case study: a qualitative naturalistic research model was used to understand the experiences of midwives and the meaning attached to the concept of autonomy within the profession. A phenomenological approach was selected for this study to guide the research process and to assist the researcher to

reach the main aims of the study. Phenomenology is commonly understood in either two ways: as a disciplinary field in philosophy, or as a movement in the history of philosophy. The discipline of phenomenology may be defined initially as the study of structures of experience, or consciousness. Phenomenology was chosen because it allows the study of experiences and the meanings things have in our experiences of events, others and oneself.

Qualitative research can be criticised in that it is strongly subject to researcher bias and that the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions. It was crucial in this study to set aside any bias, everyday understandings, theories, beliefs and judgements for myself as well as the interviewees, therefore the method of “bracketing” was utilised; where the phenomenologist is required to put all assumptions aside or into “brackets” to allow the descriptions to arise from the “first-person” point of view in order to ensure that the respective item, in this case autonomy, is described exactly as it is experienced by the participants of the study.

The study included twenty-five midwives within the Independent and NHS sector who were selected for interview by utilising purposive and snowball sampling techniques. Five areas of midwifery practice were chosen as each had a different model of care for the women and with regards to the flexibility and range of work for the midwives in each area. These ranged from private midwifery led community care in the woman’s own home to a birth centre and a high-risk obstetric labour ward:

- Independent Sector – private midwifery led care in the woman’s own home
- Stand-alone birth centre- midwifery led care within an NHS birth centre based in the community setting.
- Community – NHS midwifery led care within the community of a multicultural London borough.
- Integrated birth centre – midwifery led care in a birth centre that is within an acute hospital setting and attached to an acute obstetric led labour ward.

- Labour ward – Acute obstetric led services within an NHS hospital.

All midwives and managers working within each area were given the information leaflet informing them of the study and inviting them to take part. There was no exclusion for experience or level of seniority and male and female midwives were included. Midwifery managers were contacted for the various hospitals and working areas within which the research was undertaken. They then facilitated access to recruiting five midwives from each model of care for the research.

Semi-structured interviews: All twenty-five midwives were individually interviewed using a semi-structured schedule that was designed and developed in response to the aims of the study. The aim of the interview schedule was to assist me to elicit a comprehensive account of the midwives experiences of the phenomenon and not to direct the interview process. Nine open-ended questions were included in the interview schedule. The design of the questions was done in such a way that they did not influence the formation of answers.

Analysis of data: a phenomenological design by Colaizzi (1978) utilising a seven step framework for analysing qualitative data was selected to guide the process of analysing the data collected. This included reading all transcripts to acquire a feeling of the data, reviewing each transcript and extracting significant statements, spelling out the meaning of each significant statement to identify underlying themes, organising the formulated meanings into clusters, integrating the results into an exhaustive description of the phenomenon, formulating an exhaustive description of the phenomenon and asking participants about the findings as a final validating step.

Confirmability: as the sole researcher for this study the data was checked by validation of the themes and sub themes by a sample of the interviewees as described earlier and the analysis and results discussed and debated by the research supervisors for this study.

Credibility: credibility in this study was ensured by multiple review of the field notes and audiotapes, the neutrality of the researcher doing the interview, careful handling of the emotional expressions and returning transcriptions to interviewees for verification of facts and results.

Researcher Bias: Cognisance must be given to the possibility of subjectivity on the part of the researcher who is closely involved with some of the interviewees within independent practice and with autonomous midwifery led care outside of the NHS. Throughout this study the author has borne in mind the need for objectivity in all research activities and to this end, has endeavoured to maintain an impartial stance in all interactions with participants.

Ethical Aspects: Consideration was given to the use of and access to NHS premises; consent from the Director of Midwifery for each unit was obtained. Ethical approval was sought from the School of Health and Social Sciences Health Studies Ethics sub-committee at Middlesex University and application made locally to each ethical committee at the hospitals used within my study through the online application with the National Research Ethics Committee (NREC). Authorisation was also obtained from the Research and Development Officer for women's services at each NHS Trust.

An issue for the study was that of confidentiality of information collected and anonymity of respondents. To gain the confidence and co-operation of the midwives involved I approached each participant individually and explained the purpose of the research with an assurance that their identity and the information they provide would not be divulged further.

Overall findings: Whilst respondents advocated autonomous practice, the findings did not always support this philosophy. Some responses reflected confusion in the interpretation of autonomy and what equates to autonomous practice. Education was a key issue, both within the profession itself, among NHS management and other relevant professional groups alongside this was the issue surrounding the culture of the working environments regarding hierarchical structure and its impact on the ability to practice with autonomy.

Recommendations: The study recommends

- In-house professional development programmes to address lack of knowledge regarding the concept of autonomy (to include medics and midwifery managers)
- Active involvement in hospital guideline groups and service development programmes, promotion of midwifery led care.
- Replication of this study in other areas of the UK to determine any significance to workload and place of practice would seem vital in directing the education of midwives in particular as to where they will eventually practice.
- A comparative study of work culture including hierarchical systems to determine significance to autonomous practice.

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CHAPTER 1 INTRODUCTION, RATIONALE AND OVERVIEW

This thesis looks at the nature of autonomy within the midwifery profession. A focal point of the thesis is the qualitative study that investigates what autonomy means within the realms of the midwifery profession and identifies factors that influence autonomy within practice. In this chapter the rationale for the study and a detailed account of the methodology is presented. An overview of each chapter is also provided. This study started as a Bachelor of Philosophy (BPhil) and having decided to continue with empirical work I converted to Master of Philosophy.

Rationale for the study

The impetus for this investigation into autonomy arose from my passion for the art and science of midwifery over the past sixteen years and my constant questioning of the real possibility of autonomous midwifery practice or more specifically of the parameters and limitations entailed with autonomy and how this impacts on midwifery care. A major influence on my thinking and attitude has come from my thirteen years of independent practice. I left the NHS within five years of qualifying, frustrated with the politics within such a large work system and feeling I could not offer the care I aspired to for the vast majority of women passing through the maternity services at the two hospitals I had practiced in since qualifying. I felt demotivated and unable to make autonomous decisions with an ever-changing management structure and an ever-increasing trend towards obstetric care rather than midwifery led care. Risk management and the vast amount of paperwork entailed with this also detracted from the type of care I wished to offer the women I looked after. I had observed independent practice during my NHS career in London and felt excited that this could resolve my frustrations and offer the individualised care and support that I strived for and that women, be they only a small group compared to those passing through the NHS, should have the choice of continual support and time to discuss their concerns with a midwife they knew and trusted.

My aims in undertaking this study were to clarify the different indicators of autonomy for midwives and whether practising autonomously is actually good

for the practitioner or potentially more challenging and difficult within a system that requires the accountability and responsibility of midwifery autonomy. I want to add to the body of knowledge within this area, stimulating further debate and initiating change. Thereby, affording women the choice of genuinely autonomous midwifery care and reducing the stress for midwives who practise within a constantly changing environment.

Aims of the Study

- To explore and interrogate the nursing, midwifery and medical literature on aspects of autonomous practice.
- To explore midwives views on the concept of autonomy.
- To identify factors that might influence autonomy within practice.
- To explore the effect of different working environments on midwives' autonomy.

The literature reviews undertaken include the scope of midwives practice and how this affects autonomy, the impact of supervision on autonomy and freedom of practice and the link between accountability and autonomy within a litigious society. The rationale for this will be discussed in the next section.

Critical Reviews of the Literature

According to Benton and Cormack (2000) a literature review can be interpreted as systematically reading, critically appraising, then synthesising in a coherent, structured and logical manner. The reviews explore the literature available to midwives and other health care professionals surrounding the issue of autonomy and are primarily centred on midwifery but also draw on literature regarding other similar professional groups, such as nursing and physiotherapy. The literature reviewed was confined to a maximum of seven of the more widely read journals, covering the past twenty years, to accommodate any major changes occurring within maternity care and utilising current publications and relevant other texts with the purpose of gaining an academic and professional viewpoint. The main journals used include British Journal of Midwifery, Practising Midwife, Royal College of Midwives (RCM) Midwives Journal, Midwifery the International Journal,

Nursing Times, RCM Evidence Based Midwifery Journal and British Medical Journal.

Initially a wide ranging search was carried out using the National Library for Health (formerly the National Electronic Library for Health) which provided information from a range of sources including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline Express and Midwives Information and Resource Service (MIDIRS) databases. Other supplementary sources of information were libraries; used to source textbooks and journals, and communicating during my day-to-day work with other midwives both independent and those working for the NHS. Information gained from these and relevant quotes were logged and collated on a computer in order to return to it and find common themes relating to autonomy.

Initially, the database searches were performed using the broad search parameters of “autonomy and midwives” with a view to then refining the search to common themes. Early exploration of the concept of autonomy led me to search within the area of philosophy. As little research evidence was available within the midwifery literature so the search was widened to similar professions like nursing and physiotherapy as this led to more research and empirical studies being available.

The searches were limited to English language papers and produced approximately one hundred and twenty papers made up of mainly opinion papers and discussion surrounding autonomy. The few pieces of research actually obtained were mainly quantitative rather than qualitative in design although not unexpected it would have been interesting to have more in-depth discussion data, obtained from qualitative study, as a comparison. The searches not only covered the United Kingdom but worldwide including the U.S.A, Canada, Australia and New Zealand; utilising countries where midwives can work independently as well as for the hospital system and where midwives have the ability and right to make an impact on maternity care and its services. I decided not to include developing countries because when considering the issues of different health care systems and cultural expectations around the world as well as the status of midwives in each

country the role of midwives would be unequal when looking at autonomy within the profession, for example, in some countries midwives act as obstetric nurses and in others, like the developing countries of Asia and Africa, undertake duties that would be undertaken by an obstetrician. The articles and reports included individual and group studies with involvement of opinion and discussion as well as studies of professional organisations with an uneven mixture of qualitative and quantitative research, the emphasis being on quantitative as discussed earlier.

Common themes relating to autonomy appeared in the majority of papers accessed, therefore initiating a further search using the key words 'sphere of practice', 'supervision' and 'accountability'. This produced approximately a further forty articles. A similar search was then carried out within the nursing and physiotherapy indices but it was difficult to ascertain those relevant to midwifery as nurses and physiotherapists are not entitled by law to care for patients on their own responsibility, as is the case for midwives. Therefore, the medical literature was looked at to obtain some useful comparisons

The target audience of the journals from which the articles were extracted was observed to vary considerably. Some articles were taken from journals available from newsagents such as *The Practising Midwife* and *Nursing Times* whereas others were only available by subscription, e.g. *Midwives* and *British Journal of Midwifery*. No hospital library can subscribe to all the specialist journals but will generally have a selection. It is difficult for a busy practitioner to keep abreast of the huge amount of literature available –said to require reading 19 journals a day, 365 days a year (David et al cited by Kendall and Lissaur, 2003) and so midwives may not be aware of much of this literature about their speciality. Therefore, many useful articles will not be read by practising midwives, alongside this is that the other factor influencing what midwives read is their perception of what is useful; each practitioner will have their own thoughts on what is relevant to their practice and may miss out on important information. This may then impact on their autonomy and midwifery care by not keeping updated with recent research and evidence-based practice; therefore, not enabling the midwives to offer research based information to the women and assisting in writing evidence based guidelines.

Any database used will only be as good as the data entered and any search will only be as thorough as the search information given for a particular topic. It should be acknowledged that because of the type of descriptors used to access the databases, there is no guarantee that the literature searches are exhaustive. This problem is highlighted by Riddlesperger et al (1996) who state that their exploratory analysis of the current state of nursing theory construction as reflected by CINAHL, may not have given a complete picture of their topic. Electronic searching was supported by a manual search of the indices in books to establish whether articles were being missed due to the search tools used. This was not found to be the case. It must also be noted that the search and review of articles was an on-going process to ensure reference to knowledge was up-to-date and relevant.

For the purpose of this study the review was finally divided into three sections from the themes previously discussed; scope of practice, supervision of midwives and accountability. The intention was that by dividing the literature review into distinct groups, the overlap between the themes would be minimised although noting there will always be a certain degree of overlap.

To prevent the possible bias in my decision-making of specific themes to discuss and areas of interest I gained the opinions of five colleagues, working within the NHS, on articles accessed from my search. These opinions confirmed the key areas derived from the study and ensured the study was not continuing with bias.

Empirical Research

Following the extensive literature review the research question and research tools developed further, initiating the qualitative study using semi-structured interviews to research midwives' opinions on autonomy and aspects of their profession that affect autonomy. The study included twenty-five midwives from five different practice areas within the NHS and Independent sector; each area chosen for the difference in the model of care and the range of work undertaken by the midwives. An interview schedule developed in response to the aims of the study encouraged discussion within the interviews (Appendix 7). The main parameters for these discussions being

educational and professional experience, work environment and midwives individual definitions of autonomy.

The results were analysed using a qualitative phenomenological approach designed by Colaizzi; utilised with the purpose of enhancing the understanding of the phenomenon of autonomy within the midwifery profession; the full methodology utilised for the study is discussed within chapter eight.

Overview of Chapters Two to Ten

Chapter two looks at the definitions and variations of both personal and professional autonomy and examines the concept of autonomy for midwives. It explores the decision-making processes involved with this professional role and the impact on this from a hierarchical and medical model of maternity care.

Chapter three looks at the historical context of midwifery; when and how the practice of midwifery developed and evolved into the current profession. The status of autonomy is examined within the context of the provision of maternity care in the UK.

Chapter four continues on from the previous chapter to look at the professional status of midwives and how this has developed over time within various government Acts and within the United Kingdom Central Council (UKCC)/Nursing Midwifery Council (NMC) guidance. The change within midwifery education is discussed and how this affects midwifery practice and autonomy.

Chapter five is the first of three to look at one of the common themes found when reviewing the literature on autonomy. Within this chapter the meaning of 'scope of practice' is investigated and looks at a philosophic framework as well as the association between standards of practice, core competencies, expanded practice and accountability.

Chapter six discusses the second autonomy theme, that of supervision and looks at its meaning within midwifery, how supervision started and has

progressed alongside a growing profession. Conflicts within supervision and how these might impact upon autonomy are discussed in particular managerial versus clinical supervision.

Chapter seven looks at the third autonomy theme, that of accountability discussing its meaning and more specifically to whom the midwife is accountable from the institutional perspective through to personal and professional accountability. The link between autonomy and accountability is looked at and the implications of accountability to the midwifery profession as well as the prerequisites for accountable midwifery practice.

Chapter eight discusses the methodology behind the qualitative research project looking at the research design and processes involved with the research. It discusses ethical aspects and the difficulties encountered with undertaking research within a variety of settings as well as the process of verification of data.

Chapter nine evaluates autonomy within the midwifery profession by utilising the results from the analysis of the semi-structured interviews.

Chapter ten concludes the thesis, giving an overview of the whole study and offering further questions arising from the study, ideas for further research and recommendations for the midwifery profession.

CHAPTER 2 WHAT IS AUTONOMY?

This chapter will examine the complex concept of autonomy within the context of midwifery and the decision-making processes concerned with such a professional role. It looks at the definitions and variations of autonomy both personal and professional.

Definitions and Variations of Autonomy

As a concept, the term 'autonomy' is very complex. Words such as self-rule, self-support, self-sufficiency, liberty, freedom, power and authority have been used to describe what is meant by autonomy (Marshall and Kirkwood, 2000). Beauchamp and Childress (2001) acknowledge personal autonomy as being, at a minimum, self-rule where individuals are in control of their own life and free from both controlling interference from others and from limitations, such as inadequate understanding, that can ultimately affect making meaningful choices and decisions.

Autonomy is not merely a commodity it is a characteristic of individuals who are able to organise their lives in accordance with their own desires, plans and projects (Miller, 2001). The autonomous individual therefore acts freely in accordance with a self-chosen plan. Autonomous choice-making is a method for guiding individuals in the efficient pursuit of their highly contingent preferences, merely forming these preferences, of course, is one form of autonomy; to form rational preferences is to have the capacity for autonomy. However, to be fully autonomous, in the important sense, one must have not just the capacity to form rational preferences, but must (a) be able to act on those preferences free of external constraint and (b) actually perform the action in question. That is, to act autonomously, one must have the capacity of autonomy (i.e., the ability to form a set of reasoned preferences), and must then freely act according to that set of preferences (O'Neill, 1997).

According to Beauchamp and Childress (2001) it would seem appropriate to take into account these individual characteristics when determining the degree of autonomy that a midwife can be expected to achieve. Although there is an abundance of studies exploring these characteristics, Dempster's

(1990) and Schutzenhofer and Musser's (1994) investigations and the development of their measurement instruments seem particularly relevant because of the scarcity of valid and reliable instruments for the measurement of autonomy, and the absence of tools specifically designed to assess behaviours and actions related to autonomy in practice, Dempster (1990) developed the Dempster Practice Behaviours Scale (DPBC) to measure the extent of autonomous behaviours in practice. The DPBC, is a thirty item instrument with a Likert-type format and a five point scoring system, which focuses on overt and covert behaviours, actions and conduct related to the extent of an individual's autonomy in a practice setting. From the 1000 subjects (practising registered nurses) who received questionnaires, the response rate was 57%. Analysis of these questionnaires and subsequent interviews with twenty-eight subjects resulted in a conceptual schema from which Dempster (1990) identified four dimensions of 'readiness, empowerment, actualisation and valuation', related to autonomy in practice. These findings are interesting insofar as some of the characteristics necessary for individual autonomy are identified, and the belief of empowerment as being a vital factor in autonomous practice is substantiated. Although this is not used as a tool within the study undertaken in this thesis, it relates to a theme that emerged from the data where interviewees describe their perception of the characteristics of an autonomous practitioner.

As Pollard (2003) states, from her examination of the literature pertaining to autonomy, the concept of autonomy is considered to be a personal quality that enables individuals to express its associated characteristics. These are summarised in Table 1:

Associated characteristics of autonomy
<ol style="list-style-type: none"> 1. Determining the sphere of activity under one's control 2. Having this right acknowledged by others affected by or involved in these decisions 3. Having the right and the capacity to make and act upon choices and decisions in this sphere 4. Taking responsibility for decisions made.

Table 1: Associated characteristics of autonomy (Pollard 2003, p115)

In relation to midwifery practice expressing these characteristics may vary depending on practice area, hospital policy and procedures, influence and attitude of colleagues. However, taking responsibility for decisions should be inherent within their accountability as a professional.

Freedom, Reflection and Personal Autonomy

The degree that midwives are able to demonstrate their autonomy when making decisions in the clinical setting is variable and depends on the extent of authority given to them by their place of practice as well as their own personal willingness to accept such freedom. However as being in control of one's own liberty and freedom should also involve behaving in a rational and moral way, it would be wrong to assume that autonomy and freedom are synonymous. Feinberg (1973) claimed real freedom is synonymous with self-discipline and self-restraint where the individual becomes free to make decisions concerning a variety of possible courses of action, demonstrating that the person has accepted true responsibility.

Within autonomy comes the expectation that individuals are able to rationalise their decisions and actions. In addition to the individual's personal integrity, other variables such as the interests of others, societal laws and rules, as well as organisational rules and procedures can further threaten the extent of personal autonomy the individual can have when making a decision. In other words, when working within an ever-changing environment and alternating situations the practitioner must alter her thoughts or actions according to the individual dilemma or situation concerned. This is known as the notion of 'reflection-in-action, and reflection-on-action' as proposed by Schon's 'The Reflective Practitioner' (1983). The former is sometimes described as 'thinking on our feet' (Smith, 2001). It involves looking to individual experiences, connecting with individual feelings, and attending to individual theories in use. It entails building new understandings to inform actions in the situation that is unfolding. Practitioners allow themselves to experience surprise, puzzlement, or confusion in a situation that they find uncertain or unique. They reflect on the phenomenon before them and on the prior understandings that have been implicit in their behaviour. They carry out an experiment that serves to generate both a new understanding of the phenomenon and a change in the situation (Schön, 1991).

Testing out our 'theories' or, as Dewey (1933) might have put it, 'leading ideas' allows for developing further responses and moves. Significantly, to do this we do not closely follow established ideas and techniques - textbook schemes. We have to think things through, for every case is unique.

The notion of repertoire is a key aspect of this approach. Practitioners build up a collection of images, ideas, examples and actions that they can draw upon. Donald Schon, like John Dewey (1933, p123), saw this as central to reflective thought. 'When a practitioner makes sense of a situation he perceives to be unique, he sees it as something already present in his repertoire. The familiar situation functions as a precedent, or a metaphor, or... an exemplar for the unfamiliar one.' (Schön 1983, p138)

In this way we engage with a situation. We do not have a full understanding of things before we act, but, hopefully, we can avoid major problems while 'testing the water'. When looking at a situation midwives are influenced by, and use, what has gone before, what might come, our repertoire, and our frame of reference. We are able to draw upon certain routines. As we work we can bring fragments of memories into play and begin to build theories and responses that fit the new situation. However, the scope for reflection is extremely limited when time is extremely short and decisions have to be rapid (Schon, 1994).

Conscience and Personal Autonomy

When making a decision, demonstrating self-discipline would also incorporate the ability to act conscientiously by seeking to always do what is right. Where reason and desire are in conflict, the conscience (or will) is called upon. If the will is weak, then the desire will prevail, whereas when the will is strong the reason will ultimately over rule the desire. The integrity of the personality therefore depends on the strength of the will and the capacity of the individual to exercise their critical conscience, holding beliefs with the courage of conviction and being free to make appropriate decisions: being free from impulsively or compulsively driven behaviour (Brown, 1996).

Autonomy as an Ethical Principle

It is one thing to be autonomous and another to be respected as autonomous. To respect an autonomous person is to recognise and appreciate the person's capacities and capabilities, including the right to certain views, to make certain decisions and take certain actions based on personal values and beliefs (Lysaught, 2004). Such respect for autonomy is an ethical principle. However, to what extent an individual is allowed choice in making decisions depends on their ability to rationalise, reflect and make clear judgement.

Professional Autonomy

For a professional group, autonomy is expressed in the way it defines and directs its own sphere of practice provides appropriate education and monitors its members by a process of internal regulation without interference from others (Kaufert, Glass, Freeman and Labine, 2004). Autonomy is a concept central to the definition of a midwife: "the midwife is an autonomous practitioner of midwifery, accountable for the care she or he provides" (WHO 1992, P3) and is associated with favourable clinical outcomes and enhanced satisfaction for women (Hundley et al, 1994 and Shields et al, 1998).

Whilst it is difficult to define autonomy within the complex context in which midwives work, Henry and Fryer (1995) recognise that it involves the exercise of choice and the power to make and act upon decisions. The professional autonomy of the health professional is associated with the freedom they have to make decisions consistent within defined boundaries of their clinical practice, together with the freedom to act on those decisions (An Bord Altranais, 1999)

The midwife, therefore, by the nature of statutory legislation is solely responsible for making decisions in relation to maternity care within the context of normality (NMC, 2004). No other person has the rightful power to change that decision. Also advice from others can be accepted or rejected, as midwives are ultimately accountable for their client's care. Autonomy is therefore restricted to that for which they hold authority from expert knowledge and position, which means they both decode and act on the decisions they make. Autonomy cannot be decision making alone, as the

decision is the foundation for determining a specific action or no action at all. Accountability, authority and autonomy are therefore linked as the right to self-govern and make decisions about their own clinical practice is an essential part of midwives being accountable.

However, to what extent an individual is allowed choice in making decisions depends on their ability to rationalise, reflect and make clear judgment. When midwives make decisions in practice they also need to be aware of the antecedents and consequences of autonomy that are summarised in Table 2:

Antecedents necessary for the exercise of autonomy:
<ol style="list-style-type: none"> 1. A situation exists in which a course of action is required and in which options are available 2. There is a need for the situation to be assessed 3. There is a need for a decision to be made and acted upon.
Consequences of the exercise of autonomy:
<ol style="list-style-type: none"> 1. Responsibility is taken for the decision made 2. The right to have made the decision is accepted as valid by others involved in the situation (even if disagreeing with the decision itself) 3. Personal esteem and confidence increase

**Table 2: Antecedents and Consequences of Autonomy
(Pollard 2003, p115)**

Until Pollard's work (2003) there had been no research focusing on midwifery autonomy in the UK; findings came from other studies exploring the role of the midwife and the relationships with other professionals. These studies suggest that midwives believe autonomy is not possible when practising with other professionals (Meerabeau et al 1999, Sikorski et al 1995, Pope et al 1997). Perceived barriers to midwifery autonomy include lack of recognition for the midwives' professional role, lack of professional confidence, the impact of midwifery education, the context of the working environment and the dominance of the medical profession (Meerabeau et al 1999, Meah et al 1996, Hosein 1998). In the most recent study by Pollard (2003) the majority of midwives did not fully understand professional autonomy and had mixed views on whether they practiced outside of medical and managerial control.

With this in mind, it could be debatable whether midwifery in the UK is an autonomous profession, particularly within the hierarchical and risk management systems of the NHS. The role of the midwife has historically been and still is defined by medical personnel and employers, frameworks and priorities (Edwards, 2004). As professional groups have historically been predominantly male, for example, medicine and law, such groups have been concerned in maintaining control which has consequently continued to affect the extent of the midwives autonomy to make her own practice decisions (Clark, 2004, Jowitt 2000, Donnison 1988,). To determine the extent of autonomy within midwifery today the following chapter looks at the historical perspective of the scope of the midwives' role and factors influencing autonomous decision-making.

CHAPTER 3 THE HISTORICAL CONTEXT OF MIDWIFERY

It is important to look at when and how the practice of midwifery started; to see how it developed and evolved into the profession it is today and to examine the status of autonomy in the context of the provision of maternity care in the UK. Aspects of this chapter have relevance to the empirical data of this study of autonomy with regard to the relationship between autonomous midwifery practice and the dominance of medical colleagues, a hierarchical system such as the NHS and practice area such as midwifery led units or birth centres.

As women gave birth, they sought and received care from supportive others. At an unknown point in the cultural evolution, some experienced women became designated as the wise women to be in attendance at birth. Thus, the role of midwifery began. Indeed, midwifery has been characterised as a social role throughout recorded history, regardless of culture or time (Donnison, 1988). Biblical recognition of the functions of midwives included several verses recounting the experiences of two Hebrew midwives who refused to kill male infants in defiance of the King of Egypt (Exodus 1:15-22). Other verses in the Bible also make passing references to midwifery attendance at birth, implying that it was ubiquitous (Genesis 35:17; 38:28).

The profession continued without major changes throughout the centuries, even through the Dark and Middle Ages (Brucker, 2000). The midwives of these centuries generally continued to learn by the apprentice model. As an apprentice, skills and knowledge were shared from generation to generation without any controlling interferences from other parties (Brucker, 2000).

However, the history of midwifery has been a long struggle between firstly, a male dominated priesthood and, subsequently a system of organised medicine also controlled by men, and a women's community-based network of helping and healing.

In the mid-1870's about 70% of all births were attended by midwives and took place in the home (Donnison, 1988); midwifery was an integral part of

working-class life and culture with them, the midwives were already seen as the advocate for women and asserting autonomy within midwifery care. The midwife was a known and trusted supporter of women, who attended the majority of those who were unable to afford medical fees. During this time the high maternal and infant mortality and the lack of education and training of the female midwives were of increasing concern; although this was also an issue for medics (Dunn, 2005). In an attempt to improve midwifery practice the Midwives Institute was founded.

Midwives Institute

The forerunner of the Royal College of Midwives, the Matron's Aid or Trained Midwives Registration Society, was founded in 1881. Zepherina Veitch, a midwife who had worked with the poor in London, together with a number of her colleagues established the Society and aimed to "raise the efficiency and improve the status of midwives and to petition parliament for their recognition".

Shortly after its founding, the Society changed its name to The Midwives' Institute and started a 20 year-long campaign to petition parliament for the regulation of midwives and midwifery. In this campaign they faced growing opposition from doctors who saw their livelihood being threatened by the wider availability of well-trained and affordable midwives. The National Health Service swept aside these social deterrents by making maternity care free for all. This is obviously still the case today, although within NHS the variation on facilities and services for pregnant women within individual NHS trusts differs greatly.

Private obstetric care is still an option for those who can afford it, which continues to offer anaesthesia and instrumental delivery within a plush environment. The other private option for women is being cared for by an independent midwife where continuity of midwifery care is offered within the homes of the women booked with them, mostly birthing babies in the home environment but also offering support to women requiring transfer to obstetric care. Independent midwifery could be viewed as the only autonomous midwifery service although this was not supported in the empirical data of this study. An explanation of independent care is discussed later in this chapter.

In 1902, the Institute's efforts were successful with the passing of the first Midwives' Act for England and Wales. Gaining professional status for midwives was an achievement for women from women and proof of their determination to establish the scope of their practice and show their autonomy. Witz (1992) believed it was the midwives sphere of competence that preserved for midwives a degree of autonomy in the practice of midwifery

In 1941 the Midwives' Institute changed its name to become the College of Midwives and in 1947 it received a Royal Charter and continues in the present day as The Royal College of Midwives, which is a renowned support for midwifery practice and the promotion of autonomous midwifery practice.

Midwives Act 1902

In 1902 the first Midwives Act, mentioned earlier, was passed after much opposition- particularly from the more militant midwives who feared that such an Act would involve finally surrendering their autonomy to medical control (Anisef & Basson, 1979). The Act required that midwives had a standardised training and a national register and it established a midwives' regulatory authority, the Central Midwives Board (CMB) and initiated the process of Supervision of Midwives, which continues to this day with the aim of ensuring the highest possible quality of midwifery care and ensuring public protection.

Heagerty (1997) relates that while the Act provided the power to reform midwifery practice it also affected the mother-midwife relationship because her loyalty was to the profession. With the benefit of hindsight this act may be seen as a double-edged sword, as it served to place midwives under the control of both the medical and nursing professions and consequently to erode the autonomy of midwives.

Independent midwifery

When the Independent Midwives Association was first founded in 1985, there were three members, by 2004 there were forty-seven and now in 2008 there are approximately 120 members. The association exists for the dissemination

of information about, and support for, independent midwives, and to lobby for the traditional role of the midwives (IMA, 2008).

Independent midwives are fully qualified, carefully regulated midwives who work on a self-employed basis outside the NHS. Most of these midwives specialise in home birth, and they are often experienced in more complex cases such as home birth after caesarean, or breech or twin birth at home or in hospital. They are passionate about their job and supporting women's choice and have opted out of working for the NHS because they feel it has become increasingly difficult within the NHS to provide the standard of woman-centred, autonomous midwifery care they wish to give (IMA, 2008). They are specialists in normal birth and use midwifery skills unfettered by NHS Trust policy and protocols, which can be obstetric-led.

Unfortunately this service is under threat in the UK. The government is proposing by 2009 to make it compulsory for all health professionals, including independent midwives, to have professional indemnity insurance (PII), which covers for negligence claims. In parallel the European Parliament is also considering similar legislation and in Australia this has already occurred. At present there is no such insurance available for independent midwives in the UK, this legislation will therefore impose a condition on this particular group of midwives that is impossible to fulfil. They are effectively proposing to make it illegal for midwives to work on a self-employed basis. This is an enormous restriction on choice for women and midwives and having insurance would not necessarily improve outcomes for mothers or babies.

Overall, it can be seen that despite a free NHS there remain inconsistencies in the type of care available for all women, whatever their background and dependent on where they live and the types of service available to them as well as the possibility of their only other choice for midwifery-led care being removed without consultation from the women themselves. These inconsistencies can also be seen to impact on the feasibility of autonomous midwifery practice either within the NHS or as an independent midwife.

The National Health Service (NHS)

The formation of the NHS in 1948 provided the public with free general healthcare, including maternity care and consequently further affected the scope of the midwife's role. As a result a more rapid shift towards hospital and maternity home births was experienced and by 1958 the home birth rate had fallen by 34%. Moreover the GP became the first contact for pregnant women and this in turn limited the midwife's autonomy as she was less able to discuss maternity care options with the woman and make appropriate care decisions. In 1974, a further influence on restricting the community midwives freedom to practise was the National Health Service (Reorganisation) Act (HMSO 1973). This meant that hospital and community midwifery services were to be centralised and managed within one organisation, namely within the hierarchical structures of the hospital. Consequently, the relatively autonomous community midwives were subject to control by others (Kirkham, 1999). The scope of the midwife's role and therefore their autonomy was constantly under threat in the 1970's due to increasing technological advances and obstetric intervention. Midwifery became a subordinate profession that was hospital based and under the demeanour of the obstetricians (Johanson et al, 2002). This in turn led to a falling normal birth rate although consequently with the use of intervention so did maternal mortality. With the view that hospital based birth and obstetric advice led to a reduction in maternal mortality; the Health Department's Maternity Advisory Committee, chaired by Sir John Peel (President of the Royal College of Obstetricians and Gynaecologists (RCOG)) presented its recommendations for remedial measures in The Peel Report (1970).

The Peel Report

Despite any substantial evidence, the Peel Report (DHSS 1970) recommended that there should be 100% hospital births and that small isolated obstetric units be phased out and replaced by consultant and General Practitioner (GP) Units in general hospitals. This recommendation confirmed the spurious desirability of hospitalised obstetric management of labour within a framework designed to limit choice for women and to also threaten midwives autonomy and scope of practise within the community setting. The principle assumption behind this being that hospital delivery was safer for both women and their babies (Tew, 1998). However, this could be

challenged on the basis that there has never been an assessment of safety of hospital births.

The Short report (1980) followed on from the Peel Report (1970) and looked at maternity care from the aspect of perinatal mortality rather than maternal mortality and came to the same conclusions as the Peel Report. Although the Peel and Short Committee Reports both recommended that full use be made of midwifery expertise, these same recommendations pointed in the opposite direction. The disappearance of home midwifery and increased medicalisation within hospital birth meant that midwives were losing their role as the experts for normal birth. Midwifery skills were devalued in favour of interventionist methods and which many had to adopt against their professional judgement (Reid, 2002). For those who disapproved some left the profession to practise privately and some opted to fight the trend from within the NHS. Protests also came from childbearing women themselves, their complaints supported by healthcare user organisations like the Natural Childbirth Trust (NCT), originally founded in 1956 and then renamed as the National Childbirth Trust in 1961 and in 1959-60 women showed their own autonomy and wrote letters of complaint to newspapers and broke the taboo of discussing childbirth in public. These letters gave rise to the voluntary organisation of AIMS, to fight for the redress of grievances (Wilmington, 1985). The close link here was between the women's own autonomy and that of the midwives where both were advocating for each other and encouraging or developing confidence in acting autonomously. Perhaps autonomy is most likely to occur when supported within groups rather than by individuals.

Alongside the above voluntary agencies, local Maternity Services Liaison Committee's were established, as recommended by the Short Committee in 1980, in order to enable the users of care to influence the provisions made for maternity services.

Maternity Services Liaison Committees

The first report of the Maternity Services Liaison Committee (MSLC) was published in 1982 within which the problems from the previous decade were considered at a national level by representatives of the professions concerned. In this report called "Maternity Care in Action Part 1: Antenatal

care” (HMSO, 1982) the role of the midwife as an autonomous practitioner caring for women during pregnancy was carefully endorsed in the section ‘Effective use of midwives skills’:

“In particular, midwives are trained to give care and advice throughout pregnancy, including the detection of abnormal conditions and their referral for medical advice where appropriate. Neglecting to use these skills, or their ineffective use, results in low satisfaction for midwives, wastes financial and manpower resources and ultimately leads to a poorer service to pregnant women” (1.10 HMSO, 1982).

However, this endorsement did not survive into the second report “Maternity Care in Action Part II: Care during Childbirth (intrapartum care) published in 1984 (HMSO, 1984). The sections ‘Clinical Operation Policies’ and ‘Role of the Midwife’ advise that operational policies should define the responsibilities of midwives and the procedures they follow (4.3,4.4). The report also states that ‘Normally the midwife will be the key person supporting the mother.’ No indication of the status of the midwife in relation to her professional colleagues was affirmed. The degree of autonomy midwives could exercise in practice would appear to have been dependent on how rigorous the operational policies were.

The third report “Maternity Care in Action Part III: Care of the mother and baby (postnatal and neonatal care) (HMSO, 1985) made no reference to the role of the midwife other than the assumption throughout that the midwife is the principal care giver in the immediate postnatal period. This would appear to show the deterioration of the role of the midwife in giving continuity of care as the expert in healthy childbirth and thus affecting their autonomy.

Despite the reports being described as guides to good practice they were never challenged. Midwives could continue to give care but that care was directed and determined by the medical profession.

The Griffiths Report

Increasing concerns to meet the demands of technical change and an ageing population, whilst constraining public expenditure within the NHS led, in 1983, to a team of business men led by Sir Roy Griffiths to advise on the effective use and management of manpower and related resources in the NHS (DHSS, 1983).

Griffiths was the agent who brought political power to bear in the government's desire for more effective fiscal control of the NHS. The creation of the NHS had been based on the acceptance of autonomy of the medical profession by the State in decisions about the use of resources. The medical profession had accepted the right of the State to set budgetary constraints within which it worked (Klein, 1995).

The profound reality of the substance of the report was the transformation of administrators to managers. Strong and Robinson (1990:138) reported that 'Nurses and midwives had the reputation of being the weakest members of the old district management team and were the group who suffered the most in the Griffiths reorganisation.' The new management structure gave the NHS a single line of command from the top to the bottom of the service. Charlton (2000:18) describes the effects as 'a fundamental reform of philosophy with managers now making regulations rather than just implementing them. They are committed not partial; they give orders rather than offering advice; they commission new wheels rather than oiling existing ones'.

The outcome of this changed approach to managing the NHS meant that nurses and midwives were now formally subordinated to the decisions of general managers (Harrison et al, 1992). This engendered hostility within the nursing and midwifery profession because both had lost the right to be managed exclusively by a member of their own profession and their automatic representation on district management teams (Klein, 1995). A weakness of the Report lay in the assumption that it was possible to change the style of the NHS without also re-engineering the dynamics of the system. The drive for efficiency made explicit by Griffiths started to bring clinical autonomy into question. If performance monitoring was to be a key to the Governments desire to decrease expenditure through objective setting and

the achievement of targets then the clinical discretion of doctors could be challenged when it was perceived to be compromising performance indicators (Davies, 2000; Arah et al, 2003).

At this time nurses and midwives had only limited training in management skills (Leathard, 2000). The apparently self-contained managerial system in nursing was based on clinical management of nursing alone and did not involve the general management functions of planning, controlling, staffing, budgeting, organizing and directing (Leathard 2000, p70). It is said that organisations are political systems where managers play an important role in society, in such cases power is often seen as more important than achieving specific objectives (Bartlett et al 2003, p159). When senior management do not play an effective role this can affect knowledge sharing as reported by Lin and Lee (2004, p108):

‘Senior management has a role to play in establishing an environment, which encourages knowledge sharing’.

The management structure chosen by nurses had served the purpose of strengthening the professionalism of nursing and midwifery but was detrimental in the rapidly evolving NHS. This however caused a boom in employment but with no budget to accommodate them so eventually the boom turned to bust and budget deficits grew thus producing a freezing of posts and occasionally redundancy. In 2006 the Select Committee on Health undertook an enquiry into these deficits and produced a document on the effectiveness of workforce planning, including clinical and managerial staff (HOC, 2007). It recommended that workforce planning must be a priority for the health service to improve workforce productivity, improve retention of staff and extend and enhance the skills of existing staff and to improve the quality of managers within the NHS; the emphasis of this being a shift to primary care and collaborative working across all areas of healthcare. If undertaken fully this could be beneficial to midwifery care and the improvement of autonomous practice with Consultant midwife roles being utilised to their full potential in the support of normality and autonomous midwifery practice.

Alongside this Hunt and Symonds (1995) discussed the cultural context of midwifery practice in the NHS with the industrial influences of shift systems, line management, production targets and the attempts to regularise an unpredictable work pattern. Individual and work cultures are said to influence how people and organisations function and relate with one another. Understanding such cultural differences can be used to anticipate potential problems within an organisation (Bartlett et al 2003, p155). Research appears to point to different cultural profiles of organisations where the underlying cultural meaning of an organisation can then be interpreted as systems of tasks versus systems of relationships (Bartlett et al 2003, p167). Therefore, the work culture that the midwives work within can impact upon their practice, whether supportive or restrictive of autonomy. It is also dependent on the characteristics of other health professionals within a hierarchical system such as the NHS. This can impede the ability of midwives to operate autonomously due to “office politics”; for example, a lack of personal development and encouragement through to doctors’ dominating a situation, which is within the scope of a midwife. In the absence of such hierarchy autonomy between midwives is said to improve, (McCrea & Crute 1991, Sikorski et al 1995, Pope et al. 1997, Meerbeau et al. 1999).

Such encouragement, from both peers and management, mentoring employees with clear and consistent direction for the encouragement of autonomy could be said to affect an individual's self-esteem, personal values and development. Gardner (2001) believes self-esteem is based upon a person's view of themselves as members of an organisation, where he states:

"High organisation-based self-esteem employees are more effective, on average, than their counterparts."

The issues of hierarchy and managerial control on autonomous practice are clearly seen within the empirical data of this study. Midwives need to ensure they are seen as an important part of the organisation of the NHS. Robinson (1990) lists a variety of schemes that midwives initiated during the 1980's in response to the perceived undermining of their contribution to maternity care and to increase their dominance within maternity services. Examples include

midwives clinics, midwife led delivery suites for low risk women and midwife led antenatal assessment units. Continuity of care from early pregnancy to the end of the postnatal period was also highlighted by Robinson as a significant issue to midwives at this time. Midwives were keen to develop models of care, such as team midwifery, which utilised all their skills. The 1980s also saw an acceleration of the development of midwifery research to enhance practice, which had been activated in the 1970s (Beck, 1980; Riordan, 1987). The development of midwifery research is crucial to the enhancement of the midwifery profession and how it is viewed by other professionals as well as to ensuring midwifery care is relevant and evidence based and the profession respected as being autonomous.

During the 1980s an undercurrent of public and official dissatisfaction, driven by the inability of the NHS to meet the legitimate expectations of its consumers, was blamed on under funding by the Government (Salter, 1998:5). In 1989 the Department of Health published a paper titled *Working for Patients* (HMSO, 1989). It was designed to tackle some of the continuing problems within the acute services such as financial control and resource allocation; The White Paper incorporated the characteristic themes of the Conservative Social Policy: performance and efficiency, consumerism and managerial autonomy (Mohan, 1995).

One of the features of the organisational processes of the new trusts, in England, was their freedom to determine local pay structures. Employers sought to increase efficiency by giving lower grades more responsibility without enhancing pay as well as increasing the managerial responsibilities of higher clinical grades. This resulted in some midwives (particularly in the community) regaining some of the autonomy lost in the hospitalisation of births but without the enhanced pay that accountability and responsibility would have earned them two decades ago.

Chamberlain (1991), writing as editor of *Modern Midwife*, was critical of the White Paper's omission of the contribution of midwives or consideration of the needs of pregnant women. Her contention was that market forces could bring about the demise of midwifery without an active marketing campaign by midwives to promote their own profession. She viewed the issue as a power

struggle, which would require midwives to ensure that they were represented in the new clinical directorate structure. Chamberlains conclusion was that 'if we do not gain inclusion in management decisions, we will have managers and obstetricians identifying a contracted role that will meet the criteria for an obstetric nurse but not an autonomous midwife' (Chamberlain, 1991:6).

The Winterton Report

There was no further major analysis of the provision of maternity services until the House of Commons Health Committee (under the chairmanship of Nicholas Winterton) started an enquiry into the Maternity Services in 1991. Consumer groups such as the National Childbirth Trust (NCT), the Maternity Alliance and the Association for Improvements in the Maternity Services (AIMS) exerted pressure for recognition of three principle demands (Bradshaw and Bradshaw, 1997b):

- Improved continuity of care
- Improved choice
- The right of women to have control of their own bodies in all stages of pregnancy and birth

All of which impact on autonomy for both women and midwives and if implemented would be a huge turning point in the provision of maternity services and for the midwifery profession. The Winterton Committee recognised 'the right of midwives to practice their profession in a system which makes full use of their skills to provide full clinical care throughout pregnancy, in labour, at delivery and in the postnatal period and which respects their legal accountability' (House of Commons Health Committee, 1992: xxxvi) although interprofessional rivalry between midwives and medical colleagues was also recognised in the report. It, however paved the way for midwives to exert their professional status and prove their autonomy.

Ball (1993) drew midwives attention to the difficulties of implementing the Winterton proposals within the mechanisms and constraints of the internal market system of the NHS. However she recognised the opportunities for providers to develop new patterns of maternity care such as midwifery-led

services, which in turn would have the added benefit of increasing midwives autonomy and scope of practice.

The NHS Management Executive identified the development of midwifery-led services as a key target following The Winterton Report. This was a huge opportunity for midwives to seize the initiative and promote the effectiveness of midwifery through autonomous practice. However, the commitment to innovation by midwives with a vision of how good services could be was severely frustrated by the limited local resources available to support change in practice.

Changing Childbirth

The Governments response to the Winterton Report was to set up an Expert Maternity Group to convert the recommendations into a transformation agenda for maternity services. The outcome was Changing Childbirth (DOH, 1993). This document identified recommendations for improving maternity services and more importantly itemised ten indicators of success with specific targets to be achieved within five years. The report represented an opportunity for midwives and their managers to make fundamental changes to maternity care which would be of immense benefit to both women and midwives.

Thomas and Mayes (1996) drew attention to the challenges of increasing midwifery autonomy and the associated personal accountability that the proposals would generate. The two previous decades had seen a diminution of the midwives role within a medical model of care and a consequential curtailment of professional expertise.

Bradshaw and Bradshaw (1997b) reflected on the professionalizing strategy that Changing Childbirth offered to midwives but they contend that the Report has had little impact on the division of labour and the distribution of power and status of midwives within the maternity services as a whole. They also suggest that midwives remain controlled more by organisational rules and regulations than by autonomous decisions and suggest that 'in the final analysis, many midwives will be far from displeased if nothing really changes'.

Much of what was recommended in *Changing Childbirth* is reiterated in more recent Government documents, discussed later in this chapter. The same key issues only partially implemented within Maternity Services in the UK and the midwifery profession continually striving to achieve autonomy and be seen as a leading profession but perhaps in truth this is an unachievable goal in the provision of maternity services as a whole. The element of autonomy as an ethereal concept certainly evolves from within the empirical data of this study as discussed in chapters nine and ten.

The New NHS and Making a Difference

The first White Paper published by the new Labour Government was “The New NHS- Modern, Dependable” (DOH, 1997). It highlighted the need for primary care that meets the needs of the patients, not the institutions, and aimed to implement integrated care (Coe, 2000). Although no specific reference was made to the maternity services the proposed development of Primary Care Trusts and their links with Acute Trusts would impinge on the care provided by midwives in the community. The Audit Commission (1997) recommended that as much antenatal care as possible should be provided in the community.

“Making a difference” was published in 1999 with the specific purpose of strengthening the nursing, midwifery and health visiting contribution to healthcare (DOH, 1999). This document makes specific reference to the role which nurses, midwives and health visitors are expected to play in enhancing the quality of care through involvement in ‘developing and implementing national service frameworks and clinical governance’ (DOH, 1999:44).

With supervision of midwives already in place within maternity services midwifery was one step ahead in relation to clinical governance which allowed midwives an opportunity to display leadership and act as role models whilst clinical governance was developed throughout the NHS. However, despite the contribution midwives could make to the implementation of clinical governance the interpretation of evidence-based practice was mixed amongst professionals; both those writing and implementing guidelines and

those monitoring their use. This aspect of evidence-based practice is discussed further in the following chapter on education.

The NHS Plan

An ambitious plan for reform and modernisation of the NHS was announced by the Government in July 2000(DOH, 2000). The implications for midwives in this ten-year programme are far-reaching. Recognition of the contributions of midwives to the health of the community was confirmed with increased pay and affirmation of the potential benefits of increased autonomy for midwives was made with an obligation for NHS employers to permit midwives to undertake a wide range of clinical tasks which could lead to greater flexibility and independence in professional practice. With the implementation of Consultant Midwife posts since 1999 and midwifery managers having closer relationships with those who decide on financial input to maternity services, midwives have been given the opportunity to contribute to the redesign of maternity services and show themselves as the leaders of autonomous midwifery care. This is also corroborated by the recent government initiatives outlined in the National Service Framework (2004) report and Maternity Matters (2007), both of which value midwifery care and choice for women and are discussed later in this chapter.

The NHS today is structured very differently from when it began in 1948. The Department of Health, led by the Secretary of State, is the government department responsible for setting the overall direction of the NHS. It sets national standards designed to improve service quality. Authorities and trusts are the different types of organisation that run the NHS at a local level (Appendix 1). The onus on maternity healthcare today is the way in which it is funded, the majority of midwives are employed by an acute trust yet may practice within a community setting which comes under the umbrella of the primary care trusts (PCT) who control 80% of the NHS budget. This can cause difficulties for midwives scope of practice and autonomous decision-making, when working within an area governed by a PCT but employed by an acute trust.

National Service Framework (NSF)

The National Service Framework for Children, Young People and Maternity Services (Children's National Service Framework) (2004) is a 10-year programme intended to stimulate long-term and sustained improvement in children's health. It is intended to lead to a cultural shift, setting national standards for the first time and resulting in services which promote high quality, women and child-centred services and personalized care that meets the needs of parents, children and their families. The NSF is aimed at everyone who comes into contact with, or delivers services to children and young people. Appendix 2 shows the specific standards for maternity (standard 11). A few aspects of these standards have particular relevance for autonomous midwifery practice with regard to the promotion of their professional status and the emphasis on midwifery-led care, as shown in Table 3:

- | |
|--|
| <ul style="list-style-type: none">• In pre-birth care, women are able to access a midwife as their first point of contact and all women are supported by a known midwife throughout their pregnancy'.• All women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth• All services facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby. |
|--|

Table 3: NSF Standard 11: (DOH, 2004)

Maternity Matters

Maternity matters: choice, access and continuity of care in a safe service (2007) was published for commissioners, service providers and other organizations involved in the provision of maternity services. It highlights the Government commitment to developing a high quality, safe and accessible maternity service through the introduction of a new national choice guarantee for women. This will ensure that by the end of 2009, all women will have choice around the type of care that they receive, together with improved access to services and continuity of midwifery care and support.

Both the NSF and Maternity Matters have a huge impact for midwives in encouraging birth away from the high risk setting, for example at home or in a birth centre and brought an exciting time of change for the midwifery profession in reinventing midwifery as the lead profession in normal maternity care and moving away from obstetric input that had crept in slowly over the years. These in turn meant midwives had to increase their professional autonomy and regain their confidence in promotion of themselves as a 'force to be reckoned with'

Conclusion

Whilst maternity care has been subject to specific and influential government reports, it is notable that the clinical autonomy of all healthcare professionals has been challenged by the service changes over the last twenty years. The issues around power and control are cyclical and there are clear parallels between what has happened to midwifery autonomy and the apparent erosion of the bastions of medical autonomy.

This chapter has shown that although government policies in recent years have given midwives the opportunity to strengthen professional autonomy, putting a strategy in place to secure this has been inhibited by organisational structures in the NHS. Modern health care is moving back towards care managed in the community and by midwives as a whole and in doing so is reversing much of what has been detrimental to the professional status of midwives and the autonomy of childbearing women.

CHAPTER 4 EDUCATION AND PROFESSIONAL STATUS OF MIDWIVES

Following on from the historical context this chapter looks at how the professional status of midwifery has developed how changes in education affect midwifery practice and autonomy.

Statute

In July 2002 midwifery in England and Wales celebrated its centenary as a profession regulated by statute. Although midwives have practised in formal and informal ways for hundreds of years professional registers have only existed for the last 106 years in the United Kingdom with the implementation of The Midwives Act 1902, discussed earlier, and later followed by other acts with varying impact for the midwifery profession. The 1902 Act established the Central Midwives Board to monitor and train midwives.

The Central Midwives Board (CMB)

The board had responsibility for keeping a register of certified midwives, determining conditions of entry, approving training and exercising discipline. The early requirements for a person to be eligible to register required approval by the church; remnants of which continue today with the 'declaration of good character.' Despite the Act's ban on unregistered midwives after 1910, it took 30 years before these were eradicated.

The majority members of the board were male medics with an honorary female laywoman to represent the interests of childbearing women. It was not until 1920 that midwives were "allowed" to be members of the board with the proviso that they did not constitute a majority.

The board also provided for local supervision of midwives through the agency of Medical Officers of Health, therefore not only were midwives subjected to stricter control than with other professional regulation but at national and local levels were placed under the governance of the medical profession.

Midwives Act 1936 and Briggs Report

The Midwives Institute discussed earlier provided continuing education for midwives, which was formalised within the Midwives' Act 1936 and established the midwife teachers' diploma and in addition made provision for 5-yearly refresher courses and established regulations regarding return to practice after a period away from midwifery. It introduced a salaried midwifery service where local authorities were responsible for the provision of the service and they would employ midwives to carry out the functions of that service.

Later in 1970 a committee was set up under the chairmanship of Professor Asa Briggs to review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role. The Briggs Report (DHSS, 1972) made many far reaching recommendations some of which were subsequently taken up. Many were relevant to education but some referred to the statutory framework for the professions and were incorporated into the Nurses, Midwives and Health Visitors Act 1979.

Nurses, Midwives & Health Visitors Act 1979, 1992 & 1997 Health Act 1999

The introduction to the act stated:

'An act to establish a Central Council for Nursing, Midwifery and Health Visiting and National Boards for the four parts of the United Kingdom; to make a new provision with respect to the education, training, regulation and discipline of nurses, midwives and health visitors and the maintenance of a single professional register'.

The first act of 1979 was one of the last to pass through parliament before the resignation of the Labour government led by James Callaghan. With its passing the CMB's for England Scotland and Wales were dissolved along with the joint council in Northern Ireland and numerous other statutory bodies. They were replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1983).

Nursing and Midwifery Order 2001

From a practical point of view this is the legislation that governs the midwifery profession. It covers the areas previously covered by the 1997 Act but provides for a new governing body, the Nursing and Midwifery Council (NMC) and a new structure to the Professional Register. Most importantly the decision was made to have three parts, one each for midwifery, nursing and public health practitioners thus paving the way for a new health professional by 'direct entry'.

During the preparation of this order there had been a great deal of anxiety for midwives, however had it not been for the midwifery response, coordinated and hard fought by the RCM, the existence of a Statutory Midwifery Committee would have been lost and midwifery interests would not have been protected. The conclusion being that the committee would have consultation rights and a professional majority in determining all midwifery matters. Another hard fought battle was to retain statutory supervision despite some midwives considering it to be a professional straightjacket (Jones & Jenkins 2004, p33).

The Nursing and Midwifery Council (NMC)

The NMC took over from the UKCC in 2002 with a year overlap period in order to maintain effective regulation while the new body determined its future structure and developed its policies and standards (Thomas, 2002:16). The structures, functions and working practice reforms that the shadow NMC identified had to be in line with the NHS Plan (DOH, 2000).

One of the functions of the NMC is to translate the relevant secondary legislation into readable directive and guiding documents for its practitioners. The first such document published by the NMC was a new version of the Code of Professional Conduct (2002) which came into force just two months after it became the formally established professional body and which recently has been updated again in May 2008.

The Code: Standards of Conduct, Performance and Ethics

Midwives are guided, along with their nursing and health visiting colleagues, by a code of professional conduct which has both 'implications and imperatives' for midwives' practice (Lewis 2002b: 30). The clauses in the document are phrased in a general manner, in order to apply to all practitioners governed by the NMC. The Code (NMC, 2008) (Appendix 3) clearly indicates to the practitioners themselves, their employers and the public the standard of care expected of the relevant professionals and also the individuals accountability for their practice (Dimond, 2002). Paul Lewis the alternate member for midwifery on the NMC stated that the standards set by the code are no more than 'whispers in the wind' unless we apply them ourselves and audit our practice (2002b: 30).

In addition to this midwives had two specific midwifery documents to consider within their practice; the Midwives Rules and the Midwives Code of Practice. However, the NMC in 2004 replaced both of these with a booklet containing the rules and standards for midwifery and statutory supervision of midwives. It also provides guidance on the interpretation of those rules and standards.

The Midwives Rules and Standards

The Midwives Rules (NMC, 2004) (Appendix 4), are determined under a Statutory Instrument (OPSI, 2007); they translate the governing principles of the parent legislation into a working document. The rules are amended when legislation changes or when there is a need to provide clear direction relating to new or evolving issues. Until 1986 the rules were somewhat restrictive with headings such as 'Restrictions of Treatment' (UKCC, 1983:s3, p15). They served their purpose at the time whilst midwifery moved towards a better-educated and more professional practice. However, for practice to move on it became necessary for the rules to be sufficiently broad to allow development and innovation whilst maintaining boundaries of safe practice. Some midwives still maintain that the rules are too restrictive and impact on their ability to assert their autonomy (Jones & Jenkins, 2004, p36).

The Midwives Rules is a document that covers the education and registration of prospective midwives, followed by rules to govern practice once a midwife is admitted to the register. The Practice Rules with relevance to this study of autonomy are specifically Rule 3: Notification of Intention to Practise, Rule 6: Responsibility and Sphere of Practice and Rule 12: Supervision of Midwives.

Rule 6 determines the breadth of autonomous clinical practice for which the midwife has responsibility. Some midwives feel that the rules are restrictive (Jones & Jenkins, 2004, p36) although this was not the case with the study undertaken for this thesis and discussed in chapter nine. However, this rule covers any care or treatment that a midwife has been trained to give, relating to pregnancy, labour, the puerperium and neonatal period. This is a very broad remit and allows for innovation and creativity, depending on the needs of mothers and babies, which could mean some variations in policies and practices in different areas. In 2004, with the new edition of the rules the breadth increased further with the Governments intention that the public health remit should be increased (DOH 1999:66, NHS Executive, 2001:3).

It also makes clear that the midwife must refer to appropriate practitioners in cases where there is a deviation 'from the norm which is outside her current sphere of practice' (NMC 2004: Rule 6(3)). However, what is defined as normal when referring women is debatable. In recent years more midwives are undertaking ultrasound scanning or vacuum extraction so perhaps this would then be regarded as the norm in some circumstances or hospitals (Tinsley, 2001). As new aspects of practice become part of the midwife's role it is essential that midwives have effective education and training in order to fulfil their responsibilities.

Both Rule 3 and 12 are discussed in chapter 6 within the literature review on supervision and autonomy.

Midwives Code of Practice

Although this has now been replaced by the NMC Rules and Standards (2004), the Code of Practice is discussed here as it has relevance to the history of statute and the autonomous practice of midwifery. This code determined how the Rules should be upheld and provided an ethical underpinning to professional law (Montgomery, 2002:14). It provided explanations and standards appropriate to every midwife, regardless of her place or type of practice- community, hospital, whether in the NHS, private or independent practice. Where the midwives rules had been restrictive until 1986, a midwives code of practice was prescriptive in its explanation of how to practise within the rules.

A midwives code of practice also listed the activities of a midwife as laid down in the European Union Directive 80/155/EEC Article 4. This Directive stated clearly the minimum activities that midwives should be able to undertake. The Directive was very important to UK midwifery as whilst it is in existence midwives could not become obstetric nurses as is the case in the USA and it informs the education programmes for pre-registration student midwives, those returning to practice and further development of registered midwives. At the point of registration all midwives should be fit for practice and purpose; therefore competent to undertake all the activities at a basic level.

Policies, Procedures and Guidelines

National and local Trust policies and procedures affecting maternity care may enable or inhibit the midwife to make autonomous decisions. This is dependent on the guidelines being formulated with midwifery input. Jowitt (2001) stated that the National Institute for Clinical Excellence (NICE) guidelines affecting midwifery practice have been developed based on obstetric and paediatric principles rather than midwifery ones. Therefore midwives need to assert themselves and gain a voice to support their own interests and those of pregnant women. Midwives who are confident and assertive in decision-making are considered ideal role models and the scope of their role is appreciated and specifically their ability to make autonomous decisions without the interference of others.

Midwifery Education

In the last decade fundamental changes have taken place in the education and training of future midwives with the transfer of midwifery education from schools of midwifery into Higher Education Institutions (HEI's). Over two-thirds of graduates from education programmes for entry to practise midwifery emerge from direct entry courses (NMC, 2007). Three-year programs are available in England and Wales at degree and diploma level and in Scotland all programs are at diploma level. Midwifery education programs for nurses are of 18 months duration throughout the UK and tend to be at degree level. There have been calls to finish offering the 18-month program, however, in its document *Fitness for Practice* (UKCC 1999) the UKCC Commission for Nursing, Midwifery and Health has recommended that both types of education should be retained. All midwifery education programs in the UK run on a 45 weeks per annum basis and theory and practice are integrated in a 50/50 per cent ratio.

In the UK, a government directed system ensures that the education of midwives addresses workforce requirements. The government gives funding and directives to the 'Trusts' (health service providers) regarding the numbers of midwifery students who should receive practice placements. The Trusts then contract with the universities of their choice who will provide the midwifery education program. Unlike the Australian system where some universities report difficulties securing practice placements for their midwifery students (AMAP, 2001), the UK system should ensure that midwifery education is driven by service provision and that practice placements are assured within all programs, however, placements are becoming more difficult in the UK as well.

Preparation for Autonomous Practice

The UKCC Commission (UKCC 1999) identifies that the increased numbers of three-year programs has provided an opportunity to address the issue of midwives taking more responsibility for women in continuity of care models. Some concern has been expressed about the practical skills of newly qualified midwives from the 18-month programs in terms of the requirement for midwives to be autonomous practitioners on registration (UKCC 1999). Since midwifery is seen as a separate profession to nursing in the UK, the

education programs are not built onto nursing, as is the case in Australia. It is therefore thought by many that 18 months is too short a time to get enough experience to become an autonomous practitioner (Personal communication, Midwifery Officer ENB).

UKCC Review of Midwifery Education

The UKCC document *Fitness for Practice* (UKCC 1999a) resulted from extensive consultation, three research projects and 450 responses to questionnaires from individuals, professional bodies, hospitals and education institutions to illicit opinion about pre-registration nursing and midwifery. The report noted that the most positive responses were from students and newly qualified practitioners. Three broad themes emerged from the document: the need for more and better practice, greater flexibility, and improvements in partnerships between higher education and service providers.

The effectiveness of midwifery education with regards to competency is well documented (Fraser et al, 1996, 1997; Ball et al, 2000; Leap et al, 2003). However it is Pollard's (2003) study that interestingly found that midwives educated via the direct-entry route were perceived to be more capable of exercising autonomy in practice decisions than the nurse trained midwives. This could be due to initiatives within the HEI teaching programme, for example, Problem/Enquiry Based Learning (PBL/EBL) which provides students with a greater depth and breadth of knowledge, research awareness and ability to be assertive and challenge practice. Although the academic level of midwifery education has improved there is still need to increase autonomy in decision making by boosting confidence in the knowledge of normal birth through specific modules relating to normality and even though this is incorporated into education programmes today with student midwives also having caseload care for pregnant women, in reality autonomy is not something that can be taught or acquired.

Further to the *Fitness to Practice* document the Department of Health (2001) produced the policy 'Working Together Learning Together' which endorsed partnerships between NHS, HEIs and the regulatory/professional bodies. Within this the sharing of common and core skills was highlighted as a way of gaining a better understanding of different health professional roles and with

the introduction of Interprofessional Team Objective Structured Clinical Examinations (ITOSCE's) able to make decisions together and recognise the full extent of each others role (Symonds et al. 2003). Autonomous practitioners, therefore, acting as role models and encouraging others to be the same.

The noticeable change with those providing maternity care is their attitude. Whilst midwives appear determined to be thought of as autonomous practitioners, their medical colleagues now appear more willing to allow them to practise autonomously (Marshall & Kirkwood, 2000). This, however, was not reflected in the empirical data of this study, as discussed in chapter nine, with results showing that medics are still a hindrance to midwifery autonomy.

Post Registration Education and Practice (PREP)

Since 1936 there has been a statutory requirement for midwives to update themselves professionally. Initially this was prescribed but over time more flexibility was included until in 1995 it became a completely flexible practitioner-led process that applied to nurses and health visitors as well. At the same time the professional body introduced three yearly re-registration and the two were directly linked, in that the PREP requirement had to be fulfilled in order to be eligible for re-registration.

For a midwives to re-register they must demonstrate a minimum of 35 hours of reflective updating during the preceding three years and a minimum of 450 hours of midwifery practice during the preceding three years (NMC, 2008). They must self-declare to the NMC that they have achieved the requirements. When the practice requirements have not been met then the midwife will need to undertake an approved return to practice course (NMC, 2008).

There is a system for the auditing of a small percentage of professional portfolios, which should hold the evidence of the PREP achievements. Having signed the declaration, should a practitioner be found to have declared falsely, the case would be investigated with regards to misconduct. However in midwifery few cases of false declaration are likely to occur because of the safeguard of statutory supervision.

Evidence Based Practice

The growth of and ease of access to information gathered through research has rapidly increased available knowledge about effective practice, facilitated by information technology, which allows universal access to massive databases of information. Evidence based medicine has become a core concept not only in the drive to improve clinical effectiveness but also in the drive for managerial control over professional spheres of practice.

Wickham (2000: 149) argues that what she terms 'evidence-informed midwifery' is very different from evidence-based medicine because it is not dominated by science (often cited as evidence from randomised controlled trials), but it is a composite of science, past practice, precedent and other sources of knowledge. Page (2003:45) suggests that midwives should ask two fundamental questions which are at the core of evidence based midwifery:

1. Is what I intend to do likely to do more harm than good?
2. Am I spending more time doing the right things?

Therefore Page acknowledges that it is not possible to know everything but the more important issue is to know how to find out and to be autonomous in doing so.

The search for knowledge and understanding is integral to intelligent midwifery, epitomised by the midwife who is observant and sensitive, an effective communicator and a reflective practitioner (Cluett and Bluff, 2000). The skilled midwife will be able to both use and apply research evidence to benefit the woman she is caring for; as long as she reads it. It is therefore important for midwives to develop the skills, which allow them to critically appraise research.

One of the major controversies associated with evidence-based practice is the implication it has for professional autonomy. Clinical decision-making is increasingly expected to be transparent and supported by official guidelines, policies and protocols. Accountability for decision-making is demanded from both managers and the public, who have a desire to reduce the risks associated with health care. No field of health care is more aware of this than

obstetrics and midwifery. The publication of *Effective Care in Pregnancy and Childbirth* (Chalmers et al, 1989), as the first example of synthesis and publication of summarised results of controlled trials, has been profoundly influential in developing an evidence-based for both obstetrics and midwifery.

However midwives must continue to develop their research skills so that they are empowered rather than rendered impotent by the political and managerial ideologies associated with what constitutes evidence. Midwives who practice with a comprehensive knowledge base develop skills and a breadth of knowledge, which gives them the confidence to be autonomous practitioners: confident to act in the best interests of women and their babies whatever the circumstances.

Conclusion

This chapter has reviewed the various changes in the regulation of midwifery by way of primary and secondary legislation, to the current position. The passage of midwifery over the last 100 years has not been easy but it has shown it is a force to be reckoned with and its function of protecting and promoting the health of mothers and babies is highly valued. The formation of the new professional body, the NMC, and the main documents of direction and guidance, including the rules and codes are generally seen for their positive rather than restrictive nature.

Recent developments in midwifery education have rarely been instigated by the profession nor formulated in terms of the needs of women and babies. Whilst some gains have been made, there are many weaknesses in the current framework, particularly in the relationship of theory to practice.

The current structure of midwifery education is leading to a disintegration of midwifery theory and practice, in terms of its geographical configuration and the role of midwifery educationalists. This has many negative effects; on midwife teachers, midwifery students and on those midwives in practice who are being asked to undertake roles for which they are inadequately prepared, supported and remunerated. At the same time, few if any courses are geared in content and methods primarily towards developing midwives who can be "with women".

Midwifery education can be much more creative and ambitious in what, how, whom and where it teaches and how it facilitates learning. Midwifery education should consistently and holistically work towards recruiting and nurturing the sort of midwives women need and want.

CHAPTER 5 SCOPE OF PRACTICE

Scope of practice as a term has a variety of meanings amongst midwives, other health professionals, health organisations and consumers of midwifery care (Schuiling & Slager, 2000). For some it refers to the Standards for the Practice of Midwifery, for others it encompasses the legal base of practice; still others equate it with the components of the clinical parameters of practice. Because “scope of practice” is dynamic and parameters of practice can be impacted by many variables, succinctly defining “scope of practice” is difficult (Bekemeier & Butterfield, 2005).

In a broad sense, “scope of practice” is used to describe the range of practice for the profession. In a narrower sense, it is used to determine what a midwife can or cannot do, summarised in Table 4:

- | |
|--|
| <ol style="list-style-type: none">1. Describes the practice of midwives2. Identifies which clients midwives can provide care to3. Identifies skills that midwives should or should not possess4. Assists in the development of practice guideline5. Gives a framework for usage in clinical incidence. |
|--|

Table 4: Terms of Scope of Practice (UKCC, 1992)

The reason for multiple interpretations of “scope of practice” probably arises from two sources. First, the emphasis given to midwifery expertise is the care of normal, healthy women. While it is recognised and accepted that midwives are the experts on normality, the health condition of the mother does not define or limit a midwife’s “scope of practice” (Burst, 1990). Secondly, “scope of practice” evolves and changes over time due to a number of variables including community needs as well as the midwife’s philosophy, education and years of experience, government laws and national standards and the policies and procedures of the hospital or institution itself (Varney, 1997). Figure 1 summarises the composition of the Scope of Practice as described by Schuiling and Slager (2000) but adapted for this study and UK practice:

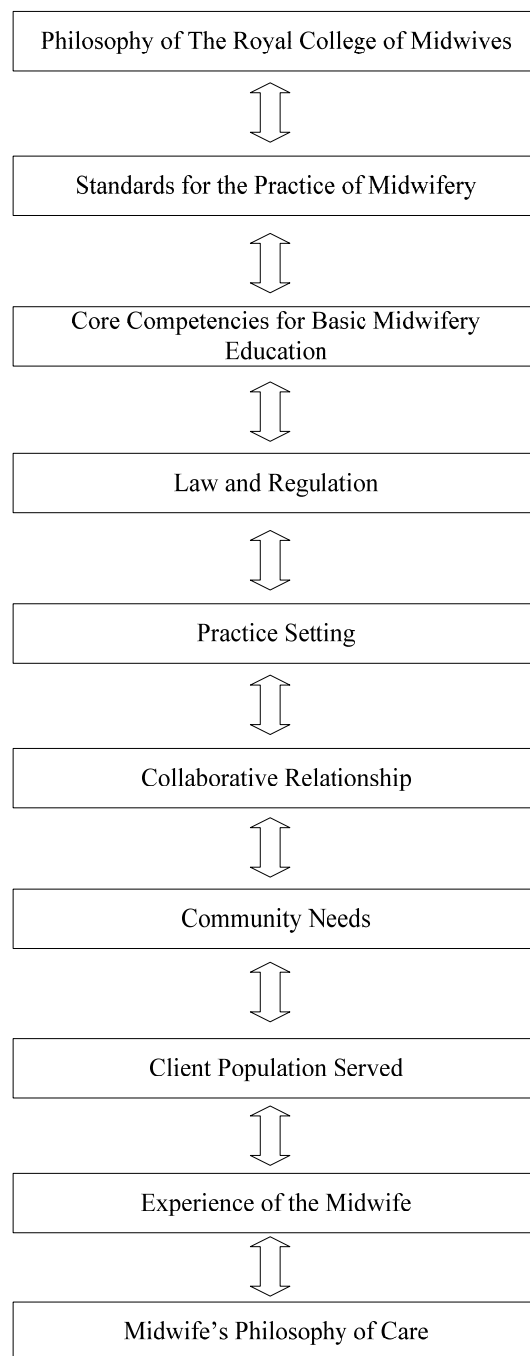


Figure 1: Composition of Scope of Practice

Philosophic Framework

A philosophy grounds midwives in their beliefs and serves to identify tenets and hallmarks basic to midwifery practice (VandeVusse, 1997).

The Philosophy of the Royal College of Midwives emphasizes safe, competent clinical management so when determining their “scope of practice,” midwives should examine if their care is safe and if it is provided at a skilled and competent level; if not then the care needed or required is not considered to be within the midwife’s scope of practice. The importance here being the midwife actually identifying their personal philosophy from their own beliefs and individual standards of care.

It is also recognised that comprehensive health care is most effectively and efficiently provided by midwives in collaboration with other members of the multidisciplinary healthcare team. Therefore it is reasonable for midwives to transfer aspects of a clients care to more skilled practitioners, particularly when it is of primary benefit for the pregnant woman.

The “scope of practice” for midwives is also defined by the International Confederation of Midwives (ICM), EU Directives and in part by the Core Competencies for Basic Midwifery Practice and the Standards for the Practice of Midwifery, which are boundaries, determined by the Nursing Midwifery Council and must be compatible with the philosophy.

Standards of Practice

“Scope of Practice” does not define a level of practice but identifies the range or extent of a midwife’s practice within specified limits. Those limits providing boundaries of midwifery practice for the profession are defined by national standards developed by the Nursing Midwifery Council (NMC) (2004), UK law and statutes regulating the practice setting. All midwives are responsible for ensuring that their scope of practice is in accordance with these minimal standards; if it is not, then the midwife’s “scope of practice” is not likely to be in compliance with legal requirements. Legal boundaries are inflexible but provide the range within which midwifery practice can occur.

Scope of practice also encompasses a midwife's knowledge, skill and behaviour as well as personal philosophies of care. The standards of practice for midwifery state that a midwife must demonstrate the clinical skills and judgements described within the core competencies for basic midwifery practice. Accredited education programmes must assure that all of its graduates have met the basic requisites of midwifery knowledge and skills and that these are reflected in their practice behaviour.

Core Competencies

The Core Competencies for Basic Midwifery Practice define the essential knowledge, skills and behaviour that all midwives possess. Maintaining competency is the midwife's responsibility and is mandated by the NMC, known as a Practice and Education Portfolio (PREP). PREP is the post registration education and practice, which the midwife should be able to 'prove' to her supervisor, or other that she has fulfilled the requirements as set out by the NMC in order to remain on the live register. It is a method of quality assurance and requires documenting, evaluating and reporting maintenance of continuing education that directly contributes to maintaining and updating practice knowledge and skills. This method of quality assurance is used to verify that a midwife's practice is current and in accordance with the NMC's Standards for Midwifery practice (2004). Although many midwives practice beyond these boundaries, the Core Competencies and Standards set an acceptable limit for the minimum scope of practice boundaries. For example some midwives assist at caesarean section. This is not a core competency of midwifery education; however, midwives can choose to receive additional training and develop skills in order to provide this service.

Expanded Practice

As science and technology advance, many midwives are expanding their skills beyond their basic core competencies in response to client, community, and/or institutional requests, particularly in settings that lack qualified personnel who can perform the procedure, for example, midwives undertaking kiwi ventouse deliveries either within stand-alone birth centres or on delivery suites. Zeidenstein suggested that a midwife's knowledge and skill base should be encouraged to stretch its limits "within the boundaries of safe practice" (Zeidenstein, 1994). It is imperative that the individual

understands that they assume the responsibility for maintaining competency in the expanded skill and that they are accountable for the care given (NMC, 2002). However, the debate here is whether this is and should be advanced midwifery practice or whether this is utilising midwives to undertake obstetric roles. This may not necessarily assist in increasing midwifery autonomy but hinder it, as midwives are renowned as the experts in normality and the support of women through normal childbirth. Undertaking assisted ventouse delivery therefore, takes the midwife into the realms of abnormality and obstetrics; this may lead to the midwife detracting from her autonomous role as midwifery advocate for normal birth and entering in an alliance with the medicalisation of birth.

Although midwives may view this acquisition as important, as such specialised roles can provide a degree of short-term 'illusory autonomy', others are more sceptical and feel the tension between what they are trained to do and what they are asked to do (Stafford, 2001). They may also face conflict between their professional accountability and fulfilling the requirements of their employers.

Laws and Regulation

Autonomy has been defined as the: "freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions" (Batey and Lewis 1982). Thus the importance of defining the scope of midwifery practice is explicit in this definition. If midwives are to exercise their autonomy they must first decide what the parameters of their practice are but these parameters have to be set within the realms of professional legislation, by the NMC (2002)(formerly UKCC) and EEC Directives (1980).

The act of registration by the Council confers on individual midwives the legal right to practise and to use the title 'registered'. From the point of registration, each practitioner is subject to the Council's Code of Professional Conduct (2008) and accountable for her practice and conduct. The Code provides a statement of the values of the professions and establishes the framework within which practitioners practise and conduct themselves. The act of registration and the expectations stated in the Code are central to the

Council's key role in regulating the standards of the professions in the interest of patients and clients and of society as a whole.

The Code includes a number of explicit clauses that relate to changes to the scope of practice in midwifery. These clauses are:

- As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:
- Act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;
- Ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;
- Maintain and improve your professional knowledge and competence;
- Acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.

The Code provides a firm base upon which decisions about adjustments to the scope of professional practice can be made. The term scope of practice refers to the range of roles, functions, responsibilities and activities, which a registered midwife is educated, competent and has the authority to perform.

Decisions about a midwives' scope of practice are complex and involve consideration of a number of important determining factors. These include the core definitions and values that underpin midwifery practice, the levels of competence and the management services, all of which are responsible and accountable for making judgements about the overall scope of practice of midwives (UKCC, 2000).

In 1992, the UKCC published *The Scope of Professional Practice*. This document was widely regarded at the time as having liberated the development of midwifery from its previous reliance upon certification for tasks, towards an acceptance that it should be limited only by the individual

accountable practitioner's own knowledge and competence (UKCC, 2000). It provides a framework within which practitioners can justify what they are able to do in order to ensure the effective delivery of care and identify what they are not in a position to do, due to lack of skills or knowledge, and how that might be remedied.

The six principles of the scope of practice were that, in taking on responsibilities beyond the traditional boundaries of practice, registered nurses, midwives and health visitors must ensure that they:

- Uphold the interests of patients and clients at all times
- Keep their knowledge, skills and competence up to date
- Recognise the limits to their own knowledge and skill and take appropriate action to address any deficiencies
- Ensure that existing standards of care are not compromised by new developments and responsibilities
- Acknowledge their own professional accountability for all actions and omissions
- Avoid inappropriate delegation (UKCC 1992)

It must be noted, however, that The Scope of Professional Practice no longer exists as the NMC produced its new Code of Professional Conduct in April 2002 and this replaced the UKCC Code of Conduct, together with the Scope of Professional Practice and the Guidelines for Professional Practice.

Experience and Philosophy of the Midwife

Midwives possess a personal philosophy of care that influences their 'scope of practice' (Schuiling and Slager, 2000). While a midwife's personal philosophy is individual the NMC and their employer stipulate their professional philosophy. A midwife's personal philosophy affects decisions related to the skills and practices she chooses to use, particularly those that may be new to her practice.

The experiential background of midwives also impacts on their respective 'scope of practice'. More experienced practitioners may choose to learn and incorporate into their practices new procedures or to expand the client

population they serve. The reasons for expanding their scope of practice may be continuity of care or increased education or that the professional body permits an expanded practice for a particular area, for example; midwives undertaking ventouse deliveries.

However a prior experience may also lead to a reduced midwifery “scope of practice”. Some midwives who have encountered difficulties within their practice, an untoward incident, been involved in clinical investigation as part of risk management or NMC procedures or perhaps unfortunately involved with a maternal or neonatal death may allow this to affect their future care of pregnant women due to lack of confidence or nervousness. Flew (1962) stated that the past does not predict the future some midwives allow it to affect practice.

Practice Guidelines

Practice guidelines are often based on the setting, the nature of the midwife/obstetrician relationship and the laws governing the “scope of practice”. In order for midwives to practice competently and to realise their potential in the interests of quality patient/client care, certain supports need to be in place. These include local and national guidelines, policies and protocols that have been developed collaboratively with practising midwives and with reference to legislation and research-based literature, where this is available. Within the developed world midwifery managers need to ensure that there are systems in place that will provide support for midwives in determining and expanding their sphere of practice.

Some midwives are unable to define their own sphere of practice, provide appropriate training programmes and monitor their own members with internal regulation, without interference from significant others. According to Frith (1996) “controlling influences from the medical profession continue to undermine midwives’ opportunities to learn, achieve and exercise their full professional role” and more recently in a study by Hyde and Roche-Reid (2004) found that widely contested obstetric knowledge and practices continue to exercise mastery over nature and undermine a central feature of the midwife’s role.

On the other hand some midwives have direct input into their written policies, which, within their practice guidelines, leaves room for exercising clinical judgement, and have somewhat flexible boundaries in reference to “Scope of practice” (Williams, 1994). Practice guidelines assist or guide midwives in making appropriate plans for patient care and contribute to their respective “scopes of practice”.

The midwife’s scope of practice is directly affected by the nature of working relationships in particular with obstetricians but this can be related to all professional groups from GP’s through to management. It is imperative that bridges are built and working relationships improved with colleagues to ensure the midwife’s scope of practice is not hindered in any way and that the boundaries are not pushed to the limit.

Accountability

Individually midwives must consider their own accountability and duty of care as they practice on a day-to-day basis and make decisions with regard to their scope of practice. A lack of clarity around the issue of accountability is seen as the major concern, which prevents practitioners from practising to the full potential of the scope. Those who wish to develop their practice may not be prepared to take the necessary responsibility for being fully professionally accountable for doing so. This was found to be the case when, in 1997, the UKCC commissioned an independent research review into the application and impact of the scope of professional practice. This review was performed in preparation for future revision of the document and to promote its principles.

The independent research company, Public Attitude Surveys Ltd, looked at the views of 10, 000 nurses, midwives and health visitors as well as a wide range of professional organisations, using interviews, questionnaires and formal observations. Generally the respondents involved in the study felt the principles of the scope were clear but they needed more detail and guidance. It was widely acknowledged, however, that there needs to be flexibility in how the principles are incorporated into practice. In particular, there has to be clarification of the balance of responsibility between individual practitioners and the organisations for which they work:

“the active support of employers, managers and colleagues is vital to the successful implementation of the principles of the scope” (UKCC, 2000).

Midwives felt that their scope of practice decision-making was centred on the way in which health services were delivered and is affected by the change in the working practice of colleagues like maternity care assistants (MCA's) and advanced midwifery practitioners.

There are undoubtedly individual practitioners who are working within the principles of the document on their own initiative. However there is a clear need for structures which support continuing professional development. The major difficulty with the scope of practice was that although it was outlined in both the EEC directive (1980) and the definition of a midwife (WHO/ICM/FIGO 1992), midwives found they were unable to practice at this level.

There is a trend towards broad, enabling scope of practice frameworks, which empower midwives as professionals to make decisions about their scope of practice and a general shift away from an emphasis on certification for tasks. Limited evaluation would appear to have taken place on the effect on practice of scope of practice frameworks. Some studies suggest that empowering frameworks, such as that of the UKCC, now NMC, are perceived as “having a positive influence on practice, providing liberation for practitioners in relation to role development and contribution to social and health care provision” (Land et al, 1996) and “enabling the development of skills and the promotion of confidence, reflection and self awareness” (Jowett et al, 1997).

Conclusion

The practice of midwifery requires the application of knowledge and the exercise of judgement and skill. As discussed in previous chapters practice takes place in a context of continuing change and development. Such change and development may result from advances in research leading to improvements in treatment and care, from alterations to the provision of

health and social care services, as a result of changes in local policies and as a result of new approaches to professional practice. Practice must, therefore, be sensitive, relevant and responsive to the needs of individual patients and clients and have the capacity to adjust, where and when appropriate, to changing circumstances.

As professionals, all midwives must determine what is an acceptable and appropriate “scope of practice” in which to provide care that is safe, competent and in line with the NMC model of midwifery care. “The scope of practice is determined equally as much by the inflexible boundaries and flexible clinical parameters as by the midwife’s own philosophy of care. Midwifery is a discipline but it is also a philosophy of care. The scope of practice does not determine who is a better midwife but identifies parameters in which midwifery care is provided. Although midwives may have very different “scopes of practice all should provide care that includes safety for mother and baby, continuity of care, advocacy and empowerment of the women who are the recipients of that care.

CHAPTER 6 SUPERVISION

Introduction

Statutory supervision as a supportive and monitoring process for midwives and the safety of mother and baby is well known within the midwifery profession (Duerden, 2002). Midwives are fully aware that it exists although its administration can vary within different working environments. When studying the literature the relationship between autonomous midwifery practice and the supervision of midwives appeared to be closely related and a commonly occurring theme.

This chapter looks at the meaning of supervision and how it started and progressed alongside an expanding profession. It specifically looks at the conflicts within supervision and how these might impact on autonomy; in particular managerial versus clinical supervision.

The Meaning of Supervision

The meaning of the term supervision is multifold. It can be defined as a control, when the effectiveness of one's actions is observed but can also be interpreted as counselling (Skoberne, 1996). The word is of Latin etymology: - super-over, videre -stare. The present use of the term should be defined according to the working context. It means either 'a look from above' or a look from the distance'. In its figurative sense, it can be understood as 'seeing things and events in the right perspective from the outside', 'a process of pondering on the effective implementation of our work affecting other people' (Kobolt and Zorga, 1999).

However, how effective the idea of looking at events from the distance is, it can be affected by the relationship between supervisor and those they supervise as stated by Hess (1980); who defined supervision as "an interpersonal relationship between supervisor and supervisee with the aim of achieving the supervisee's higher quality of work with their clients".

Supervision, of course, is not just about monitoring but about enhancing practitioner skills and knowledge. Ann Luttinkholt (1987) described supervision as:

“a process of teaching and learning where a person possessing certain knowledge and skills assumes the responsibility for teaching an individual with less knowledge and skills”.

This appears to relate to practical clinical supervision where midwives teach midwives within the practice area but in reality the process of supervision not only ensures this type of learning but to encourage learning by reflection. Dekleva considered this aspect of supervision, for psychologists and counsellors in 1995 as:

“a special process of learning, the aim of which is to encourage the reflection and self-reflection of the trainee, thus enhancing her professional competence, especially in the fields where working with people is emotionally and methodologically demanding.”

For midwives supervision is foremost a statutory role but it is also one of the possible learning processes through which a profession can gain insight into its own problems encountered in working practice and find a better way to cope with stressful situations. It helps to interrogate practical experiences with theoretical knowledge and transfer theory into practice. The final goal pursued is the autonomy of their professional performance (Kilminster and Jolly, 2000). The important aspects of supervision are also the search of one's own professional identity and the awareness of the possible and actual professional roles, as well as the responsibility and commitments accompanying those roles (Kobolt and Zorga, 1999).

History of Supervision

The Midwifery Act of 1902 established a statutory framework for supervision; subsequent changes in legislation, policy and particularly practice have additionally influenced its nature. Supervision of midwives originated in the 1902 Midwives Act (1915 in Scotland and 1918 in Ireland) as the mechanism for ensuring that the practice of all midwives complied with regulations.

Both state and medical control of midwifery practice were achieved through legislation on supervision. Statutory supervision falls into three phases:

- First the 1902 Act provided for the supervision of midwives by appointing non-midwife inspectors who 'policed midwifery on behalf of the medical profession' (ARM, 1995).
- The second phase covers fifty-five years of low profile supervision when it was embroiled in midwifery management and continued to ensure the medical control of midwifery practice.
- The last fifteen years have been a period of proactive supervision in which strategies have been developed to improve its effectiveness and place it as an integral part of maternity services quality programmes and Clinical Governance agenda.

Legislation was a way of raising the status of midwifery to make it a suitable occupation for educated women (Donnison, 1988; Heagerty 1996, Heagerty, 1997). Formerly, the inspectorial function was paramount, to protect the public by highlighting any breaches of the rules. Today appropriate standards are achieved by supervisors supporting midwives in being accountable for their own practice although their main function is still public protection and therefore stronger measures than support are required, hence supervisors are involved in audit, risk management and investigation of clinical incidents.

In 1902, no aspect of midwives' lives was safe from scrutiny. Mavis Kirkham (2000) describes how hapless midwives, whose social background was far removed from that of 'lady superintendents' wealthy enough to afford domestic help, were found to be 'unclean'. These inspectorial ladies, visiting midwives homes unannounced, found the midwives to be engaged in domestic duties such as grate polishing when they should have been about their midwifery business.

The Central Midwives Board; discussed earlier in Chapter 3, gave local authorities almost unlimited scope to investigate midwives. The Board which was medically controlled, empowered the state to investigate 'any aspect of

the midwife's practice, from following her on her rounds, to questioning her patients, to investigating her living and personal life (ARM, 1995). In a significant departure from the legal principle in Britain that one is innocent until proven guilty, the burden of proof in supervisory investigations fell on the midwife (Dimond, 2002). Vesting local authorities with powers, the Board apparently allowed hearsay as evidence. This permitted gossip, rumour or third party allegations to be used as evidence in investigations. Midwives were thus stripped of the protection afforded by judicial rules of evidence, which precluded hearsay (MacGeehin, 2001).

Direct observation of practice continues to form an integral part of supervision for self-employed midwives, at least in England, while a trend towards the scrutiny of personal attributes rooted in subjectivity, such as 'attitude', has been noted (Kirkham, 2000). Stapleton (1998) talks of 'the assumption of guilt on all sides' in the event of a complaint against a midwife. The idea here is that hearsay could still be admissible today in supervisory investigations and whether the burden of proof continues to fall on the midwife rather than on the investigator as it did in 1902. This may be seen today within hospital guidance on risk management where hearsay or intuition can be used to investigate concerns regarding clinical practice:

"some pertinent risk management issues can be picked up through ad hoc comments, hearsay or intuition. All staff have a responsibility to discuss issues with their line manger, supervisor of midwives or consultant if it relates to clinical practice" (Dartford and Gravesend NHS Trust, 2003).

Supervisors were enjoined by the state to be both 'counsellor and friend' to the midwives under their jurisdiction (ARM, 1995). The difficulties inherent in being counsellor, inspector, friend and disciplinarian were not alluded to. Hence supervision was seen, by midwives, as two-faced, which created much confusion and led to continuing difficulties (Warwick, 2007).

To start with midwives had a lack of knowledge about supervision including its official purpose and function and the framework in which it operates which was to be expected as it was a new concept and despite supervision being a

statutory obligation for over 100 years; it is only in very recent years that it has had any real meaning for the majority of practising midwives (Kirkham, 2000).

From a report by Stapleton, Duerden and Kirkham (1998); the midwives who were knowledgeable about supervision included those practising outside the NHS and midwives who had gained knowledge through being involved in an incident investigated by a supervisor or a manager.

The “carrot” of clinical support and professional development, grafted on to the stick of inspectorial duties and disciplinary powers, has given rise to confusion both within the profession of midwifery and outside it. The complaint has been made that other health professionals do not accept supervision and that it is misunderstood within midwifery (ARM, 1995).

Above all there is a serious divergence of views as to what constitutes its primary function. Supervisors see the protection of the public as their function and this is consistent with national legislation (NMC, 2002). Midwives, in contrast, believe the provision of professional support is the supervisor’s most important role (Warwick, 2007).

British Model of Supervision

In the UK the Nurses, Midwives and Health Visitors Act (1997) makes a provision for the supervision of all practising midwives by local supervising authorities (health authorities, health boards etc). A practising midwife (NMC, 2002) is appointed as a supervisor by the local supervising authority. Although more clinical based supervisors are being recruited in recent years the onus historically was on the managers ‘wearing a dual hat’ and acting as supervisors as well. This in itself has encompassed conflict within midwifery about the purpose and scope of supervision. The ‘policing’ dimension has invariably been a dominant influence and this aspect of supervision continues to be a very problematic area causing tension for some practising midwives and supervisors (Walton 1995, Leap and Hunter 1993, Kargar 1993, Flint 1985). It could be argued that the visible Edwardian roots of supervision ill fit it for the requirements of a modern, self-regulating profession. Just like the superintendents at the turn of the century, supervisors perform their duties

unpaid. Although, it must be noted, that within the last year some hospitals are offering a nominal yearly payment to supervisors practising within their NHS Trust; the majority of supervisors, however, continue to volunteer their time free of charge. Not unsurprisingly, the time allocated to supervisory duties varies; a Welsh study found that only 22% of supervisors had dedicated time for supervision (James, Halksworth and Bale, 1997). However, this study did not look at the positive aspect of the commitment given by midwives who undertake this role without numeration.

Supervision was affected by indeterminate qualifications, unclear recruitment and unlimited terms of office. The appointment process has improved in recent years with supervisors nominated by their peers, entry to an NMC regulated course is through interview with a panel of supervisors at the Local Supervising Authority (LSA) and once the course is completed and passed the LSA officer makes the final decision to allow the supervisor to practice.

Nonetheless supervisory appointments are of unlimited duration, some as long as fifteen years (Kirkham, 2000). Lack of uniformity appears to be a key feature of supervision. While supervisor's duties are prescribed, there is a wide variation in the manner in which they are discharged. In a study of supervision in England, Stapleton found 'little evidence of a coherent model of practice' (Stapleton, 1998).

Conflicts within Supervision

The individual characteristics of the supervisor, and the way the supervisor interprets and acts out the role of supervision have an impact on whether supervision is viewed positively by midwives and has an affect on their practice. Certainly one could argue that supervision is fulfilling the role of protector of the public and that of maintaining standards in the monitoring side of supervision but often the supervisor is reacting to incidents as they occur rather than continually protecting the public from potential harm from bad practice by identifying possible problems before they occur (Power, 2000).

There is a concern that supervision, which is statutory in nature and linked to a management function, may not be conducive to the open and frank communication that is necessary for clinical support. Consideration of the

types of supervision necessary for midwives in both hospital and community settings is needed. (An Bord Altranais, 1999a).

The boundaries between managerial supervision and clinical/statutory supervision can be blurred (Driscoll 2000, p63), and there is evidence of confusion between the two processes among practitioners, together with a concern that the promotion of personal and professional development, which is central to clinical supervision, could become a form of surveillance associated with management. It is clear that while the introduction of statutory supervision must be supported and facilitated by management, it needs to be differentiated from managerial supervision. Yegdich (1999) argued:

‘that until the current underlying conceptual ambiguities are identified and corrected, clinical supervision remains at risk of deteriorating into managerial supervision’.

Statutory supervision is not a managerial control system and therefore is not:

- The exercise of overt managerial responsibility or managerial supervision
- A system of formal individual performance review
- Hierarchical in nature.

Supervision and management have been difficult to separate since 1936 (ARM, 1995). In recent years, they have become almost inextricable, and many midwives are confused in consequence. The vast majority of supervisors are drawn from within the existing ranks of hospital management. (Cutcliffe & Hyrkas, 2006). This has created a climate characterised by Kirkham and Stapleton (2000) as the ‘fear factor’ in hospital midwifery. Midwives have difficulty trusting supervisors, managers and colleagues. A study in Wales found that over 75% of supervisors held managerial posts, while 33% had dual clinical/managerial functions (James, Halksworth, and Bale, 1997). Multiple hat wearing has led to discussion in the literature on the distinction between supervision and management. The ensuing perils for midwives and the difficulties in consequence for supervisors and managers are recognised.

However, the future of supervision is set to change with clinically based midwives and midwifery lecturers being encouraged to become supervisors (Kirby, 2002). This will make a huge difference to the relationship between supervisors and midwives; with supervisors seen working alongside other midwives and developing trusted positions.

The issue of supervisory roles is made more complex because of midwives different, and sometimes conflicting, expectations of supervisors. Some midwives certainly want support and an accessible supervisor, with whom they can discuss, in confidence, issues which they might not wish to discuss with their manager. They also want an advocate, one whose words has influence in wider circles. Whilst a non-manager was likely to be seen as trustworthy in terms of support and confidentiality, they usually lacked the organisational power to act as an effective advocate for midwives (Kirkham, 2000). However, in recent years as supervisors have become proactive in the process of clinical governance and development of the maternity service this view has not remained (Warwick, 2007).

The wide geographical area in which independent midwives practise affords them a more global perspective with regard to the differences between supervisors. However, some independent midwives feel particularly vulnerable with respect to the absence of any formal mechanism for appealing against decisions taken by supervisors (Flint, 2002). Sometimes this is felt to result from the supervisor confusing her responsibilities and attempting to manage rather than supervise (Berman, 2000). Some supervisors do endeavour to support independent midwives but find it difficult because of the power relationships with, and loyalties towards, their employing agency. They may therefore resort to 'doing good by stealth', usually with limited results (Kirkham and Stapleton, 2000).

Working outside the NHS with different working patterns the norm rather than the exception; independent midwives hold quite different expectations of the supervisory function and appear more pragmatic with regard to the limitations of the supervisor's role (O'Connor, 2002). Independent midwives consciously draw support from many sources including their immediate colleagues, their clients and from other health professionals. It is significant that these relationships are also used to monitor their practice through direct feedback

from one another, but within a safe environment. It can be seen therefore that where midwives exert their autonomy and are confident professionals they use midwifery supervision less.

Development within Supervision

Public protection is, of course, the primary purpose of the British model of statutory supervision (NMC, 2002). Both statutory supervision and clinical governance can be seen to undermine midwifery autonomy, as both enable the state to exercise executive control over the profession. Yet, paradoxically, professional autonomy is seen as essential to quality assurance, which links back to what midwives understand, by autonomy.

With respect to quality assurance, the judgement of Halksworth et al (1997) on supervision is trenchant: after 95 years of statutory supervision, there is little clear evidence within the literature that directly links supervision with improving quality of care for women but there is recent evidence (NMC, 2007) to show that supervision is proactive within the clinical governance structure and the promotion of quality of care.

Conclusion

Statutory supervision, although mostly unpaid, appears to have become an integral part of health service management in maternity care in Britain. Supervision is the means whereby the state continues to exercise executive control over midwifery autonomy or self-direction, the control of the content if not the terms of work, is the hallmark of a profession. However, supervision does enable development of self-assessment, reflection and autonomy, which then promotes professional autonomy. Within supervision there is a realisation that the quality assurance demanded by public safety will require equality for midwives with other care providers as well as new support structures for midwifery. The question also arising is whether supervision or autonomy is preferable and which one has real results for improving practice and ultimately the experience for the mother, baby and family.

CHAPTER 7 ACCOUNTABILITY

Introduction

The nature of accountability has been discussed since the early 1970's but it is only recently that midwifery accountability has begun to attract the attention that it deserves (Mander, 2004). This observation can be related to the midwives long-standing concerns about their autonomy as the association between accountability and autonomy is closer than is at first apparent. Midwives' long-standing attention, through history, to autonomy suggests indirectly that for all this time they have also been contemplating their accountability. As Etuk (2001) established, the twin issues of autonomy and accountability are very much bound up with the midwives' professional identity.

This chapter will look at what is meant by accountability and attempt to clarify the meaning of this term whilst looking at the various meanings that can be applied to it. It explores to whom or to what midwives are accountable and examines the relationship between accountability and autonomy.

The Meaning of Accountability

This is one of those terms that can be interpreted in a wide variety of ways, which may be due to a general uncertainty about its precise meaning.

The confusion surrounding this term is discussed by Greenfield (1975, p121-145) as he attempts to 'gather the diverse strands encompassed by accountability into a more or less coherent form'. The result of his attempt was a focus on organisational accountability; as in, the extent to which North American healthcare facilities meet the needs of the various interest groups with whom they are associated. Hence, the distinction between organisational and individual accountability is apparent.

Although it is individual or personal accountability that is mainly discussed here the implications for midwives' of organisational and institutional accountability are inevitably mentioned when considering to whom midwives' are accountable and also the implications of accountability. It could be

argued that The Nursing and Midwifery Council undervalue being accountable, defining it merely as: 'responsible for something or to someone' (NMC, 2002b, p.10). This definition suggests that accountability 'to' and 'for' are alternatives rather than it having both meanings. The alternative definition is unlikely as a dictionary definition of an accountable person indicates: 'someone who is accountable is completely responsible for what they do and must be able to give a satisfactory reason to someone for it' (CDO, 2007); therefore they are responsible for something. This definition emphasises the potential for disclosure or the preparedness to disclose the rationale for one's actions, which, as discussed below, would bring us nearer to the meaning of this term.

The concept of preparedness to disclose implies a sense of being responsible or 'explicable' (Champion, 1991). The prerequisite concept of responsibility brings Champion to discuss the authority for action and then the need for that action to be within the individual's capabilities and area of expertise. The other component of accountability, which she identifies, may be found in the possibility of needing to explain or justify an action. The need to explain or justify the choice, which was made, and the resulting actions may or may not arise, but accountability requires that the individual is always able to provide that explanation or justification. Accountability, therefore, may be seen to be about decision-making (Jones, 1994). Decision-making accountability shifts the focus from Who am I accountable to? to What am I accountable for? This requires a focus on the decisions for which one is accountable rather than on structural lines of authority (CCES, 2000).

Decision-making accountability requires that we look at the tasks that the midwife is asked to perform, the criteria for action, and how that task is performed. It then asks if the hypothetical reasonable person (the same fiction as that used in the law) would agree that the decision made was a good one. That is their decision must be correct prospectively and retrospectively as explored later.

The context within which these decisions are made is crucial to being accountable. The individual, working on the basis of her expert knowledge, must be able to exert her choice without constraint applied by others. The

discussion by Champion (1991) is applicable to the role of the midwife in the context of healthy childbearing. Champion's consideration of accountability is not dissimilar to the meanings chosen by Greenfield (1975). He defines the adjective 'accountable', from which accountability is derived, as 'subject to giving an account; answerable or capable of being accounted for; explainable'.

Like Champion, Greenfield relates accountability and responsibility to the timing of the action. Responsibility is essentially anticipatory; it precedes the action in that it permits the midwife to assume authority for the care she is about to provide on the basis of her own expert knowledge and experience. The manner in which that responsibility is subsequently manifested is in the midwife's accountability. The midwife can be seen as accountable to the organisation she works for and within the restraints of the area of practice she works within. The individual accountability is also encapsulated by the confines or otherwise of hospital policy and procedures and the culture of the hierarchical structure. Greenfield maintains that that accountability incorporates her decision making at the time of the activity and the potential for justifying her decisions and actions at a later date.

Accountability cannot exist without responsibility having previously been granted, accepted and assumed. Whether that responsibility is accepted must depend on the individual in terms of their preparation through their education and experience. In other words, a midwife may not be held accountable, or have accountability imposed on her for an action, unless she was first given and had accepted, on the basis of her professional preparation, the responsibility for caring.

Etzioni (1975) questions the reality of accountability. He argues that it may be used as little more than a gesture in terms of, for example, calling for health care providers' greater accountability to their clients. According to Etzioni, there is no intention of implementing this form of accountability and yet within independent midwifery the midwife is fully accountable to the woman who is employing her alongside her professional accountability in the same way that NHS midwives are accountable to the NHS as their employer.

In a similar vein, Etzioni (1975) demonstrates the use of accountability as a ploy in the power politics of healthcare. He shows that the more powerful an occupational or professional group becomes, then the more others are accountable to them. This is a very cynical approach to accountability but could have an element of truth within the context of midwifery practise.

The Midwife Is Accountable To Whom?

When looking at who holds the midwife accountable it is necessary to consider the areas of institutional accountability, accountability to the woman, personal accountability and professional accountability all of which can impact on the relationship between accountability and autonomy.

Institutional Accountability

Although not every midwife in the UK is employed within the National Health Service a large majority are, and some form of institutional accountability is required of them. It is possible that even the independent midwife may be held accountable to those alongside whom she practises.

The role of midwives as employees inevitably requires them, through their contract of employment, to adhere to the policies of the organisation. Although they may perceive their role as being solely to provide care to the women experiencing childbirth, their employers may require them to extend their expertise in a particular direction. This is seen in present day with midwives acting as scrub nurse at caesarean section, and undertaking ventouse delivery, whether they agree with this role or not.

In historical terms, the major organisational development that affected the midwife's accountability was the introduction of the NHS in 1948 (Tew, 1995). The advent of the NHS meant that more women were able and willing to give birth in hospital; as the levels of hospital based care increased alongside the status and power of obstetricians the scene was set for the 'technological revolution' in the early 1970's. This led to the observation that the midwife's accountability had been reduced, to the extent that she had been transformed into an 'obstetric nurse' (Walker, 1972, 1976).

The hierarchical organisational structures within which midwives continue to work serve only to diminish their accountability, as mentioned by Etzioni. The

Winterton Report (1992) and the Governments response to it (Changing Childbirth, 1993) do not appear to have fulfilled their promise to reverse the trend (Rothwell, 1996) and develop midwifery led services with benefit to and increase autonomy for midwife and mother.

Accountability to the Woman

Legislative accountability was originally intended to protect the public and the legislative framework within which the midwife currently practises continues to have this aim (Mander, 2004). Although Jones (1994) attempts to distinguish them, accountability to the public and accountability to the client are synonymous. This is because the public benefit must include the welfare of the individual woman for whom the midwife is caring. This may not be an easy concept to accept when the overall standard of that woman's care appears to be determined by the Midwives Rules (NMC, 2002) and a Supervisor of Midwives. A more direct form of accountability is that which midwives exercise in their day-to-day hands-on practice, involving the care of women, babies and families.

Midwives are accountable for facilitating women's autonomy by being their advocate within their maternity care. As professionals, midwives are obliged to strive for the best for the women in their care. But this can no longer be taken to mean that the midwife, either alone or with other health care professionals, has the right to decide what is the best course of action without fully involving the woman and her partner:

'Advocacy means taking the part of the woman and representing her interests; it also means advising her appropriately, after giving her impartial and relevant information in a form and manner she can understand' (Symon, 1995).

One of the advantages of advocacy is that the midwife is bound as a professional to offer advice and care that is at the very least competent, notwithstanding any requests made by the woman and her family.

Personal Accountability

In ethical terms the main form of accountability to carry any weight for midwives is their accountability to themselves. Jones (2003) indicates that this form of accountability is an unalterable fact of care. Caring according to one's own philosophy of life and acting consistently according to the demands set by one's own value system may call for a different standard of care than that required by any external agency. Tschudin (1989) regards this personal sense of responsibility as comparable with the way 'religious people would say that they answer to God'. However, not everyone has the same value system for standards of care and each woman will also have a different ideal for care given, therefore individual accountability will vary with individual practice.

Smith (1981) supports the crucial and fundamental nature of personal accountability, because it operates at all times, throughout the life of any healthcare provider, unlike the few occasions on which the midwife may be asked to give an account of her actions to an outside body. I would argue that this personal form of accountability is the highest form, underpinning all other forms of accountability, in that being accountable to oneself is an essential prerequisite to being able to be accountable to any other person or agent and is an essential component of an autonomous person.

In looking at the significance of personal accountability the effects of the dichotomy between personal accountability and external accountability on learning should be considered. In the event of a mistake by a care provider personal accountability might, through reflection, facilitate learning, personal growth and greater maturity. On the other hand external accountability, through legislative frameworks, may lead to little more than disciplinary action, however, a person should reflect on this as well.

Professional Accountability

Tschudin (1989), in discussing the various forms which nursing accountability may take, describes the legislative framework through which the nurse's accountability to the public operates. In the opening years of the twentieth century the equivalent midwifery framework reached the statute book two decades earlier than that for nurses. Midwives were considered essential to

solve the problems of infant mortality and morbidity, in order to lay the foundations for a healthy population from which recruits could be drawn (Robinson, 1990) but the public still needed protection from unsafe and incompetent practitioners through legislation.

This legislation emerged in the form of the Midwives Act (1902). In spite of its well known flaws (Donnison, 1988), this legislation recognised the special position of the midwife compared with other carers, in terms of her accountability for her actions. The solitary nature of the midwife's practice and her role in prescribing and administering medicines led to the need for a specific regulatory framework. This came in the form of the United Kingdom Central Council in 1992, followed by the NMC in 2002, both of which set rules and regulations for midwifery practice (NMC, 2002) as discussed in Chapter 4.

Closely linked with the Midwives Rules and Code of Practice is the role of the Supervisor of Midwives as discussed in the previous chapter. It may be that midwifery supervision is the more acceptable face of the midwife's professional accountability (Mander 2004, p138). The other side of supervision is the disciplinary procedures detailed by Symon (2002). Serious complaints by clients, police and employers are screened and dealt with by the NMC, to assess whether the charges against a midwife are proven. The question arising from this examination of the midwives' accountability is whether for autonomous practitioners such as midwives, the very existence of the statutory bodies and the associated legislative framework serves to reduce the need for them to regard themselves as accountable? Individuals may rely on the legislation and protection of a statutory body without actually understanding their actions or reasons for undertaking such actions and therefore not acting with autonomy.

Accountability and Autonomy

The relationship of accountability with autonomy is close and complex. It may be that these concepts constitute two sides of the same coin, making them effectively inseparable, but still deserving separate scrutiny due to their differing contribution to informing the midwife's role (Mander, 2002).

In discussing accountability previously it appears to be a controlling or limiting phenomenon, to the extent that it may constrain the actions of the midwife. Even the possibility of having to explain or justify one's actions carries a strong implication that there is at least the potential for an error to have been made. It therefore could be seen that accountability is a more negative concept. This impression of the negativity of accountability is reinforced by a definition of autonomy as: 'self-government or the right to self-government; self-determination' (OED, 2002). This definition carries with it the implication that autonomy is a permissive, liberating phenomenon. It may be regarded as being as positive as accountability is negative; Vaughan (1989) observed: 'some people have interpreted autonomy as meaning total freedom to act'. This clearly could cause huge difficulties within maternity services where large numbers of midwives could all act as they pleased.

Some of the limitations on autonomy may be apparent within the dictionary definition. When rights to 'self-determination' are conferred or assumed it is necessary to question 'by whom'. The right to self-determination cannot exist in a vacuum, as it carries implications for those who award it, as well as for others; some negotiation may be necessary before a 'right' is generally agreed.

Vaughan (1989) and Champion (1991) point out other limitations on the 'total freedom' hypothesis. These limitations may be categorised according to their internality or externality to the would-be autonomous individual. The former, or 'personal' autonomy focuses on the way in which autonomy only exists within the boundaries of competence, which in turn are created by the individual's finite knowledge base. The more external form, or 'structural' autonomy, implies the hierarchical or bureaucratic organisation within which most midwives practise and which inevitably limits and constrains their freedom of decision making.

In an attempt to move forward this simplistic categorisation of autonomy, Vaughan pleads for 'attitudinal autonomy', which relates to the individual's perception of himself or herself as autonomous and accountable practitioners. Attitudinal autonomy may be construed as having the self-

confidence to take appropriate decisions and to be prepared to accept any consequences that may ensue.

A significant contribution to the literature on accountability in midwifery is found in the work by Walker (1972, 1976). The major focus of the project was the role of midwives but it illuminated their autonomy in midwife-obstetrician relationships as well as their accountability. The distinction in roles had become blurred which gave rise to conflicts between expectations and practice of care. Midwives saw themselves as accountable for the care of women with no complications but their medical colleagues saw themselves, as having overall responsibility and exercising it at will. Walker's work showed that midwives understood the extent to which they were accountable but that their medical colleagues were less clear about midwives and their role. It is questionable whether this research had any continuing significance; however it is supported by more recent, though less precisely relevant, studies by Robinson et al (1983), Kitzinger et al (1990), Brownlee et al (1996) and Symon (2001).

The autonomy of those involved in the childbearing experience was clearly established in the Health Committee Report (House of Commons, 1992) and the Government response (Department of Health, 1993c). Although these documents preferred the words 'choice' and 'control', they provided answers to the question of the needs and wishes of both the woman and the midwife with regard to autonomy. These reports established the autonomy of the woman to the extent that she is to be the central decision-maker in matters relating to her care. The other major principle on which these reports are founded is the accountability of the midwife, to the extent that maternity care will be midwife-led. The existence of these reports fuelled changes in the midwife's perception of her role and practice.

The relationship between autonomy and accountability may be summarised in terms of two concurrent personal monitoring systems. Using the analogy of a continuum of internality/externality, autonomy is the more internal while accountability is marginally the more externally orientated.. The relationship between autonomy and accountability may be so close as to be barely perceptible.

Prerequisites for Accountable Midwifery Practice

Because accountability is about decision-making, the knowledge from which those decisions are derived is of fundamental importance. The need for midwives to avoid the danger of becoming complacent in their knowledge base is similar to the need, emphasised by Champion (1991), for nurses to 'develop and maintain their knowledge'. Systems are required to be in place to ensure that knowledge is updated and maintained to support professional accountability; clinical governance is one such system.

Clinical Governance was introduced to the UK healthcare system to address some of its multiplicity of problems. The concept draws on two forms of research in order to provide a sound knowledge base to achieve its aims (Sargent, 2002); these being clinical audit and evidence-based practice. As Sargent shows this reductionist approach to care serves to downgrade practice to 'midwifery by numbers'. The human 'knowledges' on which midwifery has traditionally drawn, such as intuition, occupational experience, personal knowledge and gut feeling, may no longer be permitted to feature in the repertoire of the accountable practitioner.

Implications of Accountability

Nurses and midwives are both professionally and legally accountable for their actions as Cox (2000) points out. Litigation is an increasing aspect of modern health care, and midwives are not immune from investigation or complaints (Walsh, 2000). It is more likely that nurses will be held professionally accountable rather than legally accountable, although trends suggest an increase in litigation involving nurses and midwives (Tingle, 1997).

A problem which would arise were midwives to assume full accountability is that their employers would cease to accept vicarious liability as is the case in the present day when working as an employee subservient to your employer. As long as they are working within their contractual roles, policies & procedures, their employer will take some responsibility through vicarious liability (Kanase, 2002). A midwife who is accountable would involve her being answerable to her clients for the decisions taken prior to providing care, as is the case with independent midwives in the UK. However, the fact that the employer has vicarious liability does not mean that the midwife will not

be held accountable; their professional accountability means they may still be answerable to the NMC, and their legal accountability may require them to give evidence in a sworn statement or in court (Symon, 2000). Vicarious liability only means that the employer will be liable for any damages that may be awarded. In theory, at least, the employer could claim recompense from the midwife and there is evidence of a Trust hospital doing this (Dimond, 2006).

The spectre of litigation assumes a more solid form when a midwife considers that she, like her medical colleagues, may be held responsible for any perceived or actual errors in care. Without a willingness to accept this ultimate responsibility, midwives could not regard themselves as fully accountable.

Conclusion

It is clear that there is a definite association between accountability and autonomy that is bound within the midwives professional identity. Research, which focuses more on midwives' declining autonomy, has shown that their accountability is similarly threatened. Before seeking to assume complete accountability and exercise their autonomy, every midwife must be comfortable with the increased personal costs, which this would require them to bear.

However, the emphasis here is that there may be a price to pay for accountability. This price is the cost of taking risks, personally, professionally and organisationally, and accepting the consequences of our own actions. Risk taking is an essential part of learning and the personal growth, which ensues. The restriction with this being that the majority of midwives are employed within the NHS, a hierarchical organisation which stipulates care pathways and practice thus diminishing autonomy and reducing the personal impact of accountability.

Because accountability and autonomy are linked, if midwives wish to have autonomy, they must also accept responsibility for this autonomy. For this reason accountability is as essential for midwifery to mature into a genuine profession as it is for each individual midwife to become genuinely

professional (Mander, 2004). Midwives need to step out of the obstetric bubble and take responsibility for normal midwifery care, advising on practice guidelines and advocating for normal birth. They need to be confident in their practice and prove they are not fearful of being accountable and therefore act as the autonomous professional they are meant to be.

The following two chapters describes the methodology used for the collection of the empirical data and the evaluation of the findings from the study which evolved from the main themes appearing in the literature review as explored in the previous chapters.

CHAPTER 8 RESEARCH METHODOLOGY

Introduction

A qualitative naturalistic research model was used to understand the lived experiences of midwives and their meaning attached to the concept of autonomy within the profession.

Unlike the contrasting positivist notion (Oldroyd, 1986), no causal relationships between predetermined variables are measured. The informants' ability to independently provide explanations from their own experiences is the core value in a qualitative naturalistic approach.

It is suggested that qualitative research stresses the socially constructed nature of reality; the intimate relationship between the informants and what is studied; and the situational constraints that shape enquiry. It emphasises the value-laden nature of enquiry and seeks answers to questions about how social experiences are created and given meaning. In contrast, quantitative studies emphasise the measurement and analysis of causal relationships between variables, not processes (Norman & Yvonnas, 2003).

The Overall Plan of the Research Project

A phenomenological approach was selected for this study to guide the research process and to assist the researcher to reach the main aims of the study. Phenomenology was chosen because it is a research method directed toward uncovering and describing the lived experience and the meaning of such experience from the perspective of the experiencing person (Omery, 1983; Parse, Coyne & Smith, 1986).

Phenomenology is a philosophical movement developed in the early years of the twentieth century by Edmund Husserl and a circle of followers at the universities of Gottingen and Munich in Germany. "Phenomenology" comes from the Greek words *phainómenon*, meaning "that which appears", and *lógos*, meaning "study". Literally, phenomenology is the study of "phenomena": appearances of things, or things as they appear in our experience, or the ways we experience things, thus meanings things have in our experience. In Husserl's (1983) conception, phenomenology is primarily

concerned with making the structures of consciousness, and the phenomena, which appear, in acts of consciousness, objects of systematic reflection and analysis. Such reflection was to take place from a highly modified "first person" viewpoint, studying phenomena not as they appear to "my" consciousness, but to any consciousness whatsoever.

The structure of these forms of experience typically involves what Husserl (1900-1901) called "intentionality", that is the directedness of experience toward things in the world, the property of consciousness that it is a consciousness of or about something. Conscious experiences have a unique feature; we experience them, we live through them or perform them whereas other things in the world we may observe and engage with, but we do not experience them in the sense of living or performing them.

According to Moustakas (1994), knowledge of intentionality requires that we are present to ourselves and to the things in the world that we recognise that self and world are inseparable components of meaning. The meaning is at the centre of perceiving, remembering, judging, feeling and thinking. In these activities we are experiencing something (whether actually existing or not), remembering something, judging something, feeling something, thinking something, whether the something is real or not. Conscious awareness was the starting point in building one's knowledge of reality. By intentionally directing one's focus, Husserl proposed one could develop a description of particular realities. This process is one of coming face to face with the ultimate structures of consciousness. These structures were described as essences that made the object identifiable as a particular type of object or experience, unique from others (Edie, 1987).

Husserl proposed that one needed to bracket out the outer world as well as individual biases in order to successfully achieve contact with essences. Bracketing is a process of suspending one's judgement or isolating particular beliefs about the phenomena in order to see it clearly.

Whilst Husserl is considered the father of phenomenology, Heidegger is considered the originator of hermeneutic or interpretative phenomenology. Unlike Husserl's focus on describing the phenomena in order to understand them, the focus of Heidegger's phenomenology is the interpretation of phenomena –with emphasis on cultural, social and historical contexts - in order to achieve understanding. Rather than bracketing ones assumptions in order to engage the experience without preconceptions, the hermeneutic approach requires the researcher to embed their pre-conceptions in the interpretive process. "The meaning of phenomenological description as a method lies in interpretation" says Heidegger (1962, p37). Interpretation is not an additional procedure but constitutes an inevitable and basic structure of our being-in-the-world. The focus is toward illuminating details and seemingly trivial aspects within experience that may be taken for granted in our lives, with a goal of creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991).

As all other types of qualitative research, phenomenology can be criticised in that it is strongly subject to researcher bias and that the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions. Phenomenologists accept that researcher subjectivity is inevitably implicated in research; some might say it is precisely the realisation of the intersubjective interconnectedness between researcher and researched that characterises phenomenology. As Giorgi (1994, p205) stated "nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather how the subject is present is what matters, and objectivity itself is an achievement of subjectivity".

Phenomenologists also concur about the need for researchers to engage a 'phenomenological attitude'. In this attitude the researcher strives to be open to the other and to attempt to see the world freshly, in a different way. The process has been described variously as 'disciplined naivete', 'bridled dwelling', 'disinterested attentiveness' and/or the process of retaining an 'empathic wonderment' in the face of the world (Finlay, 2008).

In considering the differences between the Husserlian and Heideggerian approaches as well as the aims of my study I concluded that the principles of the hermeneutical phenomenological approach would be more suitable. I came to an awareness of my already existing beliefs which made it possible to examine and question them in light of new evidence as well as being critical of my own subjectivity, vested interests and assumptions and to how these might impact on the research process and findings. Colaizzi (1973, p64) argues that “researcher self-reflection constitutes an important step of the research process and that preconceived biases and presuppositions need to be brought into awareness to separate them out from participant descriptions”. Gadamer (1975) describes this process in terms of being open to the other while recognising biases. Knowledge in the human sciences, according to him, always involves some self-knowledge.

“This openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it. This kind of sensitivity involves neither “neutrality” with respect to content nor the extinction of one’s self, but the foregrounding and appropriation of one’s own fore-meanings and prejudices. The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings” (Gadamer, 1975, pp268-269).

In research terms this meant that as a researcher I shifted back and forth, focusing on personal assumptions, arising from sixteen years within the field of midwifery and then back to looking at the participants experiences in a fresh way. Wertz (2005) picks up this point when accepting the value of researchers’ subjective experience when engaging the epoche of the natural attitude and during the analyses that follow from the phenomenological reduction. He suggests this process allows researchers to:

“Recollect our own experiences and to empathetically enter and reflect on the lived world of other persons...as they are given to the first-person point of view. The psychologist can investigate his or her own original sphere of experience and also has an intersubjective horizon of experience that allows access to the experiences of others” (Wertz, 2005, p168).

Researcher reflexivity in this context becomes a “process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings” (Finlay, 2003b, p108). However, the focus needed to remain on the research participants and the appearing phenomena by embracing the intersubjective relationship between researcher and researched both impacting and touching on the other and through which the data emerged. Whilst I remained constantly aware of potential influences arising from my own experiences, I did not explicitly use bracketing.

Parse, Coyne & Smith (1986) suggested that phenomenology explicitly takes into account the human beings' participation with a situation by using written and oral descriptions presented by subjects as raw data. It is through the analysis of the descriptions that the nature of the phenomenon is revealed and the meaning of the experience for the subject fully understood. It is believed that only individuals who have experienced the phenomena are capable of communicating them to the outside world. It is the major task of phenomenology to uncover the phenomenon under study. This includes not only the phenomenon itself but also the context of the situation in which the phenomenon manifests itself.

Holloway & Wheeler (1996, p118) explained that “a person has a world which is inclusive, has a being in which things have value and significance and a person is self-interpreting”. This suggests that people can only be understood by use of a research method that can examine, discover and construct meaning of the individual's socio-cultural context.

The particular phenomenological method used for the analysis of the data I collected was developed by Colaizzi (1978). This is not only a method but a philosophical framework which was used with the purpose of enhancing the understanding of the autonomy phenomenon within the midwifery context, by describing the emerging circumstances of autonomy, the experiences of the midwives and the meaning ascribed to the autonomy phenomenon. Colaizzi's method uses a seven-step process discussed in full under the section on data analysis. Significant statements, formulated meaning, theme cluster,

exhaustive description and the fundamental structure provided the unfolding of the phenomenon.

The above design and approach guided the sampling technique, the data collection method and data analysis method.

Ethical Aspects

Consideration was given to the use of and access to NHS premises; consent from the Director/Head of Midwifery for each unit was obtained. Ethical approval was sought from the School of Health and Social Sciences Health Studies Ethics sub-committee at Middlesex University and application made locally to each ethical committee at the hospitals used within my study through the online application with the National Research Ethics Committee (NREC). Authorisation was also obtained from the Research and Development Officer for women's services at each NHS Trust.

The process of ethical approval was unexpectedly lengthy, taking ten months. The main difficulty arose with the approval from the Local Research Ethics Committee at the acute unit who had concerns surrounding my access as I was working independently. The request for a named midwife within the NHS Trust who knew me, to assist me in recruitment of midwives, ease my access to the unit and be a point of contact for any queries I may have, proved difficult as the committee would not agree to use the Director/Head of Midwifery who had already been approached and given her permission for the research.

A contact midwife was eventually organised with the assistance of my supervisors at Middlesex University who recommended a senior midwife at the hospital who had previously worked at Middlesex University. Thankfully she was happy to oblige and the ethical committee approved my application after ten months from the initial application.

An issue for the study was that of confidentiality of information collected and anonymity of respondents. To gain the confidence and co-operation of the midwives involved I approached each participant individually and explained the purpose of the research with an assurance that their identity and the

information they provide would not be divulged further. A written information sheet (Appendix 6) and consent form (Appendix 7) was given to all interviewees, containing researcher contact details, for them to use for information and support throughout the study if required.

Sampling Technique

Initially purposive sampling was carried out to select the twenty-five midwives from five specific midwifery-working practices. Authors (Babbie & Mouton, 2001) argue that sampling in qualitative research is often purposeful and directed at certain inclusion criteria, rather than random. The literature (Polit, Beck & Hungler, 2001; Uys & Basson, 1985) argues that the purposive sampling is based on the judgement of the researcher regarding the characteristics of a representative sample. The researcher selects those subjects who know the most about the phenomenon and who are able to articulate and explain nuances to the researcher.

Holloway and Wheeler (1996) note that generally qualitative samples consist of fairly small numbers, from 4 to 50 participants. They emphasize that in the case of qualitative research it is not the size of the sample that determines the importance of the study. In other words, the researcher should be concerned with the quality of the sampling method and the extent to which it captures the phenomenon being studied, rather than using as large a number as possible. The study included twenty-five midwives within the independent and NHS sector, ensuring a good mix of junior and more senior members of the midwifery profession.

Five areas of midwifery practice were chosen as each had a different model of care for the women and with regards to the flexibility and range of work for the midwives in each area. These ranged from private midwifery led community care in the woman's own home to a birth centre and a high-risk obstetric labour ward, as listed below:

- Independent Sector – private midwifery led care in the woman's own home
- Stand-alone birth centre- midwifery led care within an NHS birth centre based in the community setting

- Community – NHS midwifery led care within the community of a multicultural London borough
- Integrated birth centre – midwifery led care in a birth centre that is within an acute hospital setting and attached to an acute obstetric led labour ward
- Labour ward – Acute obstetric led services within an NHS hospital.

All midwives and managers working within each area were given the information leaflet informing them of the study and inviting them to take part. There was no exclusion for experience or level of seniority and male and female midwives were included. Midwifery managers for the various hospitals and working areas within which the research would be undertaken were contacted. They then facilitated access to recruiting five midwives from each model of care for the research. For those midwives working within the stand-alone birth centre and the community this process worked well. However, within the integrated birth centre and acute unit this proved difficult with issues surrounding communication between staff and accessibility for me to undertake the interviews. A few participants were recruited this way from these two areas and then a snowball sampling method was used with interviewed midwives offering names of midwives to be contacted whom I then approached and asked to participate. Holloway and Wheeler (1996) point out that this kind of sampling method is used where the researcher finds it difficult to identify useful informants, or where individuals cannot be easily contacted.

The process of undertaking the interviews, therefore, took much longer than anticipated and meant that both purposive and snowball sampling methods were used.

Interview Schedule

An interview schedule was designed and used to guide the interviews (Appendix 8). This was developed in response to the aims of the study and encouraged discussion within the following parameters:

- Educational Impact –when the midwife trained and type of training

- Experience – within one area or mixed between hospital and community as the type of experience may impact on the value of autonomy
- Client Group – cultural issues and type of women being cared for affecting choices and decision-making
- Geographical Area – what facilities were available within the area of midwifery practice
- Context -of their own environment, from perhaps the use of technology, local policy or other professionals
- Personal Values - personal philosophy of care, personal definition of autonomy
- Support – for the midwives on a daily basis and in particular within supervision
- Job Satisfaction – within different midwifery roles and the correlation between value of autonomy and retaining staff.

The aim of the interview schedule was to assist me to elicit a comprehensive account of the midwives experiences of the phenomenon and not to direct the interview process. Informants were encouraged to express their experiences freely and share their stories fully.

Nine open-ended questions were included in the interview schedule. The design of the questions was done in such a way that they did not influence the formation of answers. When required, probing was used to support the questions in order to clarify and validate the informants' statements as well as to facilitate the cognitive and emotional description of the meaning attached to the phenomenon.

Data Collection

Individual semi-structured interviews were used as a means of collecting data in this study. These interviews were guided by an interview schedule as discussed previously. Authors (Moustaka, 1994; Munhau & Oiler 1986) suggest that interviews are the primary tools of data collection in phenomenological studies. Through the interview process the informants are given the opportunity to reflect back on their experiences and highlight the importance of that reflection. This reflection is crucial as it helps the researcher to understand the meaning of what the individual is living through.

The raw data in this study was the individual experiences of the midwives. According to Munhau & Oiler (1986, p71):

'Data are in the person, as it is the person who gives the meaning to the experiences of the day to day world.'

The semi-structured interviews were conducted in the working environment of the midwives in a room selected by them. The literature (Beck in Fitzpatrick, 1999; Parahoo, 1997) argues that phenomenological studies are conducted in the natural environment of the informants. It is believed that human existence is meaningful in the sense that persons are always conscious of their environments. As such the lived experiences can only be known by attending to the perceptions and meanings that awaken consciousness. Phenomenology helps to interpret the nature of this consciousness and of the subject's involvement in the environment. It is for this reason that phenomenological studies are conducted in the natural environment of the informants.

Interview Process

The interviews started more like a social conversation and became highly interactive thereafter. The informants were reminded about the purpose of the interview and their rights as informants. Despite the use of an interview schedule, the information was elicited without controlling or manipulating the informants. They were allowed to talk freely about their experiences and their answers were used to enlarge upon the topic and to ask additional questions. The non-verbal forms of communication such as nodding, eye contact were also used throughout the interviews.

The starting of the interviews as a social conversation was aimed at creating a relaxed and trusting atmosphere. The intense interaction between the researcher and the informants allowed the researcher to understand the phenomenon as perceived by the informant. Leininger (1985) suggests that the intense interaction between the researcher and informant in the course of the interview awakens the consciousness of the informants and allows them to recall and reveal events and feelings from the past from their viewpoint.

During the interviews the researcher listened carefully to what the informants were saying. This allowed the researcher an opportunity to develop appropriate follow-up questions. However, caution was taken during the interview not to offend the informants by insensitive body language or facial expressions. Ordinary everyday language was used and displeasing language avoided. Cormack (2000) suggests that the use of a simple language and the avoidance of jargons enhance participants understanding. The researcher also monitored for data saturation during the interviews and the interviews were brought to an end once the informants started to repeat themselves.

Transcribing

The interviews were tape-recorded and relevant notes were taken throughout the interview. These notes and the tapes were transcribed and entered into the computer soon after the interview. Process memos were written after each interview to elaborate on the context in which the interview took place.

Analysis of Data

Holloway & Wheeler, (1996) suggest that data analysis in a phenomenological enquiry aims to understand the phenomena under study. Basically, the process entails mapping out meaning from thematic analysis of the transcribed interviews. Colaizzi (1978) proposed a seven-step framework for analysing qualitative data that includes:

- Reading through the entire transcripts to acquire a feeling of the data
- Reviewing each transcript and extracting significant statements that directly pertain to the investigated topic
- Formulate meanings as they emerge from the significant statements
- Organising the formulated meanings into clusters (refer these clusters back to the original protocols to validate them, note discrepancies among or between various clusters, and avoiding temptation of ignoring data or themes that do not fit)
- Integrating results into an exhaustive description of the phenomenon under study
- Formulate an exhaustive description of the phenomenon as an unequivocal statement of identification as possible.

- Validate the analysis by returning to each subject and asking if it describes their experience.

According to Polit & Beck (2004), this seven-step framework for qualitative data analysis offers the researcher the opportunity to return to the informants for validation/verification of the results and is conformable to the phenomenological enquiry.

The principles outlined here were used to organise and analyse qualitative data generated from open-ended questions and were applied as described below.

Reading all Transcripts to Acquire a Feeling of the Data

The computer printout of the write-ups that derived from the researcher's notes, the tapes, the process memos of each interview were read through carefully while the corresponding tape was replayed in order to get a sense of the overall data. According to Bogdan & Biklen (1992) reading constantly through the data helps to identify common or regularly appearing phrases, patterns of behaviour and the informants' ways of thinking as events are repeated and stand out.

Reviewing each Transcript and Extract Significant Statements

The write-ups were transported into NVIVO ©, a computer assisted qualitative data analysis tool. These were then reread, line-by-line, paragraph-by-paragraph. These readings helped to understand the data further and to identify key statements and phrases. The identified key statements were highlighted and the common or more regularly appearing phrases or statements were identified and given codes. The coding was done to facilitate the organisation, identification, retrieval and analysis of meaningful information inherent in the data.

Spelling out Meaning of each Significant Statement

Each key statement was examined to identify the underlying theme. These statements were then cut and paste from the transcripts and labelled

according to the themes emerging from the initial analysis and collated within NVIVO ©, (Figure 2).

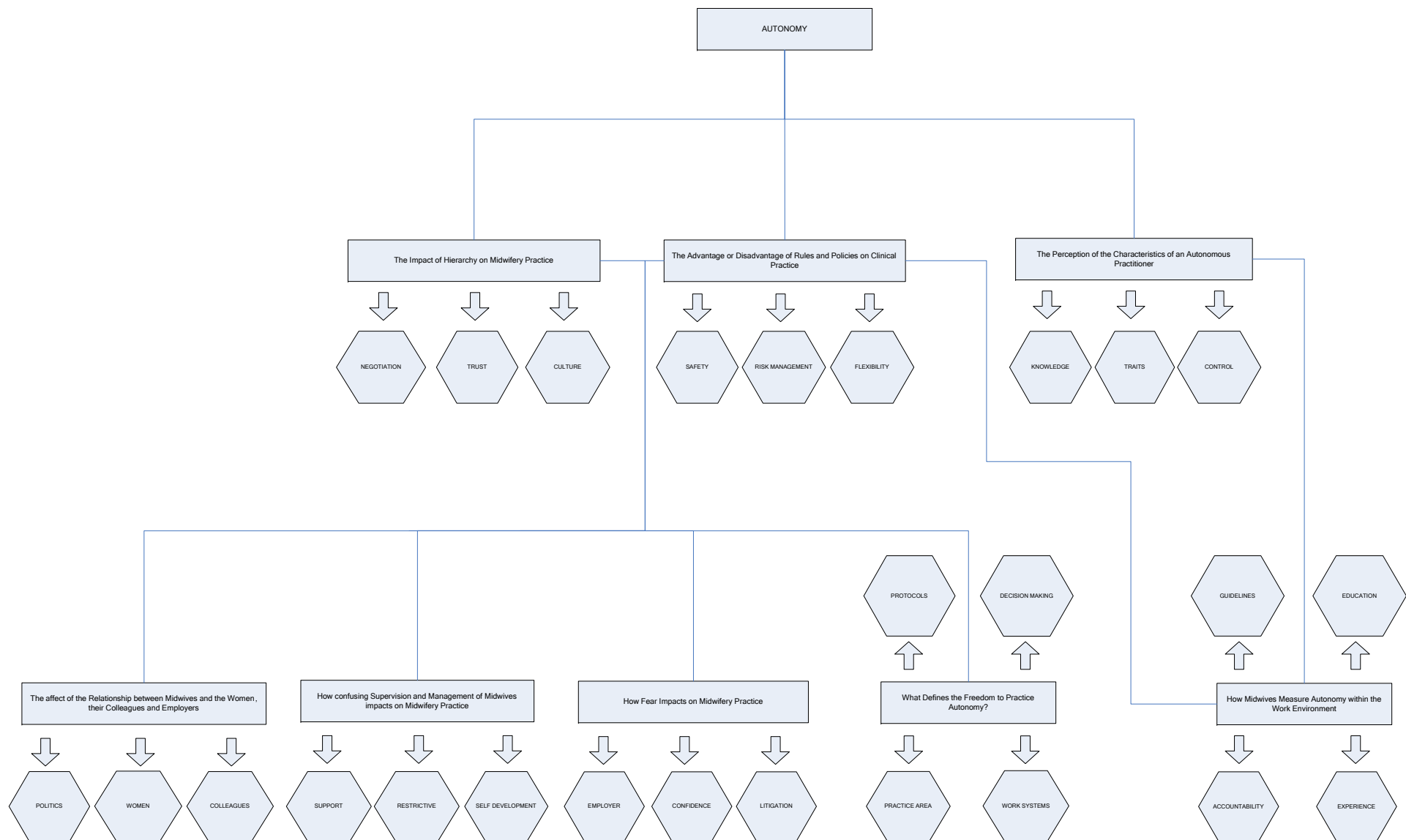


Figure 2 Underlying Themes

Organising the Formulated Meanings into Clusters

The collected data within NVIVO ©, was further analysed and organised into clusters of themes or categories. Where a great deal of data was identified, some subcategories were developed. To ensure connection between elements of stored information, formal writing was postponed until all the transcripts were reviewed and understood. Thereafter, the meaning of each cluster was formulated through an intuitive-reflective process.

Bogdan (1992) suggested that in a phenomenological study, data is usually analysed, interpreted and reported from the researcher's perspective and some meaning could be lost in the process of interpretation as people see and interpret things differently. This limitation was overcome by constantly consulting the original transcripts throughout the analysis process and by taking the findings to the informants for verification.

Integrating Results into an Exhaustive Description of the Phenomenon

Using the same process of intuitive-reflection, the meanings of clustered themes were examined to formulate an exhaustive description of the lived experiences of the midwives and the interpretation of the meaning attached to autonomy. The aim of this process was to attempt to disclose and elucidate the phenomena as they manifest themselves within the data.

Formulate an Exhaustive Description of the Phenomenon as an Unequivocal Statement of Identification as Possible

The same process of intuitive-reflection was used to develop the common meaning of the autonomy phenomenon within the context of midwifery. The descriptions of the meaning of the lived experiences of the midwives and the description the meaning attached to autonomy were examined to formulate a statement describing the essence of the phenomenon. It involved an intuitive integration of the fundamental descriptions into a unified interpretation of the experience of the phenomenon as a whole.

Asking participants about the findings as a final validating step

Several measures of validating the qualities of data collected were used. A letter requesting interviewees to verify or not the themes identified by the

researcher was sent to one interviewee, randomly picked, from four of the practice areas used in the study and a group validation session organised with the five stand-alone birth centre interviewees (Appendix 9). A flow chart of the themes and sub-themes was submitted with this letter to assist interviewees in understanding the results of the data and confirming or not the accuracy of the analysis obtained from the transcriptions (Appendix 10).

The evaluation of the quality of the data analysis is one of the most important methodological challenges for qualitative research. In quantitative research, terms like reliability and validity are used to describe the quality of analysis. Reliability and validity also refers to the consistency with which the instrument produces the results if administered in the same circumstances and to the degree to which an instrument measures what it is intended to be measuring (Burns and Groove, 2001; Parahoo, 1997). However, within the descriptive data of qualitative research, the quality of data collected and its analysis is assessed in terms of confirmability, dependability, credibility and transferability (Stommel and Wills, 2004).

Confirmability

Confirmability is similar to reliability assessment in quantitative research studies. Confirmability refers to the degree to which the results could be confirmed or corroborated by others. As the sole researcher for this study the data was checked by validation of the themes and sub themes by a sample of the interviewees as described earlier and the analysis and results discussed and debated by the research supervisors for this study.

Credibility

According to Stommel and Willis (2004), credibility involves performing specific activities that increase the trustworthiness of the reported findings. These activities include prolonged engagement, peer briefing, member checking and triangulation. Credibility in this study was ensured by multiple reviews of the field notes and audiotapes, careful handling of the emotional expressions and returning transcriptions to interviewees for verification of facts and results.

Transferability

Transferability refers essentially to the extent to which the findings can be transferred to or has applicability to other settings or groups. As Lincoln and Guba (1985, p316) noted the responsibility of the investigator is to provide sufficient descriptive data in the research report so that consumers can evaluate the applicability of the data to other contexts:

“Thus the naturalist cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility.”

This study has used a small sample to explore one concept of midwifery practice, and as such the researcher recognises that the findings refer to the particular population (mainly London based) of the midwives interviewed. One therefore is unable to predict that the same results would have emerged had the research been carried out elsewhere in the United Kingdom. However, in light of most of the findings being supported by other research studies, transferability of the findings to other areas of midwifery practice throughout the UK seems feasible.

Researcher Reflexivity

Cognisance was given to the fact that the researcher is closely involved with some of the interviewees within independent practice and with autonomous midwifery led care outside of the NHS. A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions.

Reflexivity requires awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us "to explore the ways in which a researcher's involvement with a particular study influences,

acts upon and informs such research." (Nightingale and Cromby, 1999, p. 228).

With this in mind I made records of interviewees demeanour and behaviour during interviews, maintained a reflective diary to record methodological decisions and the reasons for them, the logistics of the study, and to reflect upon what was happening in terms of my own values and interests. The importance being that thoroughness in record keeping helps the reader to develop confidence in the data.

The following chapter presents and discusses the findings for the study of autonomy within the midwifery profession.

CHAPTER 9 EVALUATION OF THE FINDINGS FOR THE STUDY OF AUTONOMY WITHIN THE MIDWIFERY PROFESSION

In the previous chapter the findings from the study were presented, and explored midwives' views on the concept of autonomy, to identify factors that might influence autonomy within practice and to explore the effect of different working environments on midwives' autonomy.

The findings are described in this chapter, incorporating the participants own words where possible in order to provide rich data, which are based in the context in which they are obtained, to develop arguments which are either supported or refuted in the literature and discuss issues evolving from the data surrounding autonomy and the midwifery profession.

Each of the eight main themes and twenty-six sub-themes arising from the analysis are discussed separately under the headings:

- The impact of hierarchy on midwifery practice
- The advantage or disadvantage of The Midwives Rules and local policies on clinical practice
- The perception of the characteristics of an autonomous practitioner
- The effect of the relationship between midwives and the women, their colleagues and employers
- How confusing supervision and management of midwives impacts on midwifery practice
- How fear impacts on midwifery practice
- What defines the freedom to practice autonomy
- How midwives measure autonomy within their work environment

Interviewee Codes

The twenty-five interviews were coded according to the five areas of midwifery practice used in the study and the five midwives interviewed within each practice area were numbered from 1-5 (Table 5). For the purpose of giving understanding to the quotations, detail is given below, on what area of

practice the codes relate to and some basic details about each interviewee with regard to age, gender, years of experience, type of midwifery education and level of seniority within the area that they work but with consideration to maintaining the confidentiality of the interviewees’.

- INM01-05: Independent Midwives in self-employed practice
- CBC01-05: NHS Stand-alone Birth Centre Midwives
- HFM01-05: NHS Integrated Birth Centre Midwives
- TBC01-05: NHS Acute unit/high risk Labour Ward Midwives
- TCM01-05: NHS Community Midwives

Table 5: Interviewee code and practice area

Midwives’ Personal and Professional Data

Interviewees’ were all female and ranged in age between early twenties to sixty with a vast amount of experience for the three nearing retirement to six being qualified for less than three years. This appeared to represent the profession on the whole, as there are only a small number of male midwives within the profession and age ranges greatly within all maternity hospitals. Two were managers, who also had some clinical input in different areas of practice, eight were senior Band 7 midwives (equivalent to a midwifery sister since agenda for change was implemented), and they were clinical leads in their practice area. Ten were Band 6 midwives with varying amounts of experience; the other five did not appear to be in a hierarchical structure as they were self-employed midwives. With regard to the interviewees’ midwifery education eight had previously qualified as a nurse and then gained a certificate in midwifery after eighteen month training, three had qualified as a nurse and then gained a post registration diploma on an eighteen month university course and one had qualified as a nurse and then gained a post registration diploma on an eighteen month university course. Twelve had gained their midwifery degree through a three-year direct entry university course and one had undertaken the same course over four years.

Full details of all the professional data is displayed in Table 6:

CODE	GENDER	AGE	GRADE	TYPE OF MIDWIFERY EDUCATION	YEARS EXPERIENCE
CBC01	F	35-40	Band 7	18mth certificate. Followed by diploma	12yrs
CBC02	F	35-40	Band 7	Direct entry degree (3yr)	13yrs
CBC03	F	55-60	Clinical manager	18mth certificate	38yrs
CBC04	F	30-35	Band 6	Direct entry degree (3yr)	4yrs
CBC05	F	55-60	Band 6	18mth certificate	35yrs
HFH01	F	20-25	Band 6	Direct entry degree (3yr)	1.5
HFH02	F	25-30	Band 6	Direct-entry degree (3yr)	8yrs
HFH03	F	25-30	Band 6	18mth post reg diploma	2yrs
HFH04	F	40-45	Band 7	18mth certificate	21yrs
HFH05	F	30-35	Band 7	18mth certificate	8yrs
TBC01	F	25-30	Band 6	18mth post reg diploma	3
TBC02	F	30-35	Band 7	18mth certificate	8yrs
TBC03	F	35-40	Band 7	18mth certificate	11yrs
TBC04	F	20-25	Band 6	Direct entry degree (3yr)	1yr
TBC05	F	20-25	Band 6	Direct entry degree (4yr)	2.5
TCM01	F	30-35	Band 6	18mth post reg degree	4

CODE	GENDER	AGE	GRADE	TYPE OF MIDWIFERY EDUCATION	YEARS EXPERIENCE
TCM02	F	35-40	Band 7	Direct entry degree (3yrs)	6yrs
TCM03	F	35-40	Manager	18mth certificate	14yrs
TCM04	F	20-25	Band 6	Direct entry degree (3yr)	3
TCM05	F	30-35	Band 7	Direct entry degree (3yr)	7
INM01	F	50-55	Self-employed	18mth certificate	37yrs
INM02	F	35-40	Self-employed	Direct entry degree (3yr)	10.5
INM03	F	50-55	Self-employed	Direct entry degree (3yr)	9
INM04	F	45-50	Self-employed	Direct entry degree (3yr)	10
INM05	F	45-50	Self-employed	Direct entry degree (3yr)	1.5yrs

Table 6: Interviewees' personal and professional data

Key Findings from the Study

The Impact of Hierarchy on Midwifery Practice

This area of the study explores the impact and relationship of the hierarchical structure within maternity services on midwifery practice. In particular the relevance to the culture of the working environment, the trust of colleagues and the importance of negotiation with other colleagues within practice to ascertain midwifery autonomy.

Culture

Individual and work cultures are said to influence how people and organisations function and relate with one another. Work cultures in the case studies differed in organisational structure, processes and even experiences,

which meant experiences of midwives varied between practice environments. The literature showed that understanding such cultural differences can be used to anticipate potential problems when transferring practices from one organisation to another or in the forming of alliances (Bartlett et al 2004, p155). Research appears to point to different cultural profiles of organisations where the underlying cultural meaning of an organisation can then be interpreted as systems of tasks versus systems of relationships (Bartlett et al 2004, p167).

Within this study the work culture that the midwives work within was reported to impact upon their practice, whether supportive or restrictive of autonomy. It was also said to be dependent on the characteristics of other health professionals within those environments and how many other people the midwives dealt with on a daily basis. It is suggested the traditional hierarchical system of the NHS impedes the ability of midwives to operate autonomously due to “office politics”; for example, a lack of personal development and encouragement through to doctors often dominating a situation that was within the scope of a midwife.

In the absence of such hierarchy autonomy between midwives was said to improve, with a large proportion of interviewees reporting that autonomy was only possible when midwives worked alone, as with independent midwifery. This supports findings from other studies (McCrea & Crute 1991; Sikorski et al 1995; Pope et al. 1997; Meerabeau et al. 1999). Interviewees’ viewed autonomy as a state involving collaboration with other professionals where relationships are important.

A midwife in the independent sector with previous experience of the NHS expressed a view that within a NHS system midwifery staff were not encouraged to be autonomous.

“...I think it is to do with the hierarchy really, we are not encouraged to be autonomous, and other professionals restrict us in our decisions...” (Midwife INM03)

However, a community midwife working within the NHS felt differently although she associates her autonomy to working within a community setting. It could therefore be seen that it is not necessarily the NHS system as a whole that does not encourage autonomous practice but particular areas of practice within the NHS and the attitude of colleagues and managers working within it:

“working in community gives me more independence, I feel I can make the decisions I need to without someone breathing down my neck. It helps that my colleagues and manager are supportive...” (Midwife TCM04)

Such encouragement, from both peers and management, mentoring employees with clear and consistent direction for the encouragement of autonomy could be said to affect an individual's self-esteem, personal values and development. Gardner (2001,) believes self-esteem is based upon a person's view of themselves as members of an organisation. He states:

“High organisation-based self-esteem employees are more effective, on average, than their counterparts.” (<http://media.jcu.edu.au/story.cfm?id=37>)

In relation to midwives this means that midwives who are valued and respected by their peers and managers have a higher self-esteem and are therefore, more effective in their working practice than those who are undervalued.

Midwives from an integrated birth centre stated that a hospital environment encouraged restricted practices, citing examples of “office politics” as a cause:

“...I think in a hospital environment you are really quite restricted. The restrictions come from all sides; management, colleagues, protocols, they all make it difficult to practise autonomously...” (Midwife HFH01)

“...I think it's very political in the NHS, there are too many managers floating around and they don't appreciate individual care and autonomous practice...” (Midwife HFH02)

This was clarified in the literature by Chamberlain (1991:6) who stated that if we do not gain inclusion in management decisions, we will have managers and obstetricians identifying a contracted role that will meet the criteria for an obstetric nurse but not an autonomous midwife.

A manager also described her perspective on autonomy being restricted within an organisation:

"...I think midwives can be autonomous but within the framework of an organisation, this is not my personal ideal but as a manager I can see the difficulties associated with allowing hundreds of midwives to act as they wish..." (Midwife TCM03)

However, she also stated that the difficulties for her as a manager lay with the lack of control over finance within a large organisation:

"...It does not matter how autonomous I am I have no control over the budget, I am trying to develop the service with a lack of staff and at the same time keep a happy workforce. It's impossible to feel autonomous with these difficulties..." (Midwife TCM03)

It is said that organisations are political systems where managers play an important role in society, in such cases power is often seen as more important than achieving specific objectives (Bartlett et al 2003, p159). However, within the context of maternity services the importance is on achieving quality of care within the parameters of safety for mother and baby. The power within management would therefore be in achieving these objectives within the restrictions of limited finance and shortage of staff.

Midwives working in an acute unit labour ward felt that autonomous practice was restricted by the conflict of interest with medical staff:

“...Obstetricians try to let you normalise someone’s birth. But other doctors you feel like you are fighting a losing battle some time nt matter how hard you try...” (Midwife TBC01)

“...They come in and do things and you don’t agree with them but somehow you find that you cannot stand up for the woman enough because there are so many of them in that environment...” (Midwife TBC05)

When considering regulated professionals, such as doctors, interviewees’ reported their domineering behaviour affected the midwives ability to be autonomous. It could be argued the action of doctors’ is beset in history, with the dominance of the medical profession over an overtly female orientated profession, like that of midwifery. However, their code of conduct, within modern working patterns, does not necessarily promote such behaviour (GMC, 2003).

- To avoid bias on grounds of sex, race, disability, lifestyle, culture, beliefs, colour, gender, sexuality or age.
- To be open about the decisions and actions they take as GMC members, restricting information only when the principles of confidentiality or the law demand it.

Within the midwife led areas of the NHS and independent practice it was felt that the culture of the environment, with less hierarchy and fewer doctors, allowed the freedom to practice autonomously. This then poses the question that it requires the absence of one professional group to enable another professional group to feel and/or act autonomously. Autonomy is described in the literature as meaning self-rule; self-support, self-sufficiency, liberty, freedom, power and authority have been used to describe what is meant by autonomy (Marshall and Kirkwood, 2000). Yet midwives in this study state autonomy comes from being ‘allowed’ to act in a certain way by others around them. This was particularly the case within a birth centre or self-employed practice:

“...I appreciate being independent, I don’t have management breathing down my neck...” (Midwife INM04)

Midwives within the stand-alone birth centre felt that there was a benefit to having a smaller caseload and closer working relationships with other members of the team:

“...the multi-disciplinary team it works fine, we have a two way flow, I am sure it is to do with smallness...” (Midwife CBC01)

Within the integrated birth centre it was felt that working away from obstetric input was beneficial:

“...There are no obstetricians hovering around and you are left to make your own decisions...” (Midwife HFH04)

This again substantiates the query on whether midwives can truly be autonomous professionals if autonomy can only be achieved in the absence of other professional groups when clearly there is multidisciplinary working in all aspects of maternity care.

Negotiation

Interviewees’ noted that within a hierarchical structure there is an element of negotiation with colleagues for the interviewees’ to maintain their own autonomy when caring for a woman. This was reported across all areas of practice, but mainly referred to obstetric colleagues rather than midwifery:

“... senior midwives undermine your autonomy and I guess you really have to be a strong person to keep going and say look let’s review this and look at the woman as an individual...” (Midwife CBC01)

“...practising the way I want to was hard and that helps your autonomy. I am a great believer in independent thinking. To have the courage to question each others practice...” (Midwife TBC02)

Some interviewees felt they should be able to negotiate with colleagues when advocating for women and assert their autonomy in the decision-making process but they felt it was not in their character, notably these midwives worked within the stand-alone birth centre and so were very much self-directed with their care and did not have medical input on a daily basis. They therefore referred to the ability to negotiate with their peers on a daily basis:

“...that is just me as a person I might not agree with it but I won’t make a fuss about it or cause an argument...” (Midwife CBC04)

“...I did have the autonomy to actually question but I didn’t bother...” (Midwife CBC01)

Advocacy means taking the part of the woman and representing her interests; it also means advising her appropriately, after giving her impartial and relevant information in a form and manner she can understand (Symon, 1995). The interviewee statements are not compatible with their duty to advocate for the woman as stated by the NMC:

‘Ensure that patients/clients are given sufficient, relevant information to enable them to make informed decisions regarding their care or treatment and to respect their participation when making such decisions’

This was also seen as an issue with midwives in the NHS acute unit labour ward who felt it was easier to agree with a course of action rather than attempt to negotiate with medical colleagues. Again incompatible with their duty to advocate:

“...If you are asked to do something you do it without asking questions...” (Midwife TBC 04)

“...I try but some days you feel that if you just do what they do then it is easier ...” (Midwife TBC05)

Both of these views indicate midwives need the ability to question and negotiate and understand their role but doctors may not wish to listen or have the respect to hear the midwifery point of view:

“...There was a complication yesterday and the doctor wanted to do every test going but there was no reason to and when we came out of the room I tried to speak to the doctor but he would not allow me to say anything...”
(Midwife TBC01)

This was an interesting comment when midwives are the experts within the realms of normality and therefore should be referring to the medical staff rather than questioning when a complication arises. This could also be seen as historical bickering between medics and midwives when midwives feel undermined and their midwifery and/or female intuition is not accepted or understood.

This conflict of interest appeared to be dependent on the working environment and culture. Midwives working within midwifery led environments like the home from home unit and stand-alone birth centres felt that medical colleagues were supportive and acknowledged the views of the midwives:

“...I think they are really supportive and that has changed over the years and they have come a long way from when they did not listen: you don’t get that any more...” (Midwife HFH05)

“...with communication instead of everyone being defensive actually listening to somebody else’s point of view and then having the skill to negotiate with them...” (Midwife CBC01)

“... I think that the obstetricians, that we have, they will listen to you, if you make suggestions, they don’t just say we will do it my way...” (Midwife TBC03)

Trust

Generally credibility in one’s role is described as a key element for success. Such credibility evolves from characteristics, which include a person’s tacit

knowledge that is shared, the relationships that a person establishes with their peers and the trust and respect that evolves.

A lack of trust or credibility between medical and midwifery colleagues within hierarchical systems can be the result of poor relationships, a polarising of roles or a lack of competence on either side. Interviewees discussed that having the trust of all members of the team was an element that was felt to impact on autonomous practice whether working within a midwifery-led unit or within the acute unit:

“...On the home from home to quite a big extent you can work autonomously although it does depend which midwife is in charge...” (Midwife HFH05)

“... It depends on how much trust they have got in you, how much responsibility they are prepared to give you. How well they know you and how you practice...” (Midwife TBC05)

It was clear from interviewees that this is a two way process as having mutual respect and the knowledge of a particular persons' practice was also beneficial to autonomous practice. This was particularly felt by the midwives working within the stand-alone unit:

“...I think it is about having that relationship and mutual respect and I think that is why all the girls here are quite respectful of our consultant and he is respectful of their opinions, which is nice...” (Midwife CBC03)

“...You have got to trust that person because when you pull that buzzer that is the person who is going to come running in...” (Midwife CBC02)

The Advantage or Disadvantage of Rules and Policies on Clinical Practice

Rules and policies are a base for midwifery practice where they affect how an individual carries out their role. The Midwives Rules (NMC, 2004) are determined under a Statutory Instrument (OPSI, 2007:1887) and cover the education and registration of prospective midwives, followed by rules to govern practice once a midwife is admitted to the register.

Hospital policies or guidelines are written to give staff a safe base from which to work in the clinical environment and allow all women to be offered consistent care that is appropriate to their individual needs. They are written by members of the multidisciplinary team, utilising national research based guidance, from the National Institute of Health and Clinical Evidence (NICE), as a base for setting the standard locally within each maternity unit. Jowitt (2001) stated that the National Institute for Clinical Excellence (NICE) guidelines affecting midwifery practice have been developed based on obstetric and paediatric principles rather than midwifery ones. Therefore it is essential that National and local Trust policies and procedures are formulated with midwifery input to enable rather than inhibit the midwife to make autonomous decisions.

This theme concentrates on their advantages and disadvantages as perceived by midwives within the realms of safety and flexibility. It also looks at the relationship with risk management and how this impacts on autonomy.

Safety

The majority of interviewees viewed the Midwives' Rules as a benefit to their practice with regard to the safety of mother and baby:

"...they are not that restrictive anyway you know you are supposed to make sure that nobody comes to any harm and I am not yet trying to harm people..." (Midwife INM03)

"...I think as a midwife you want to be safe and up to date and I think the NMC rules are not restrictive in any particular way..." (Midwife HFH02)

"...it very clearly defines what our role is and as long as I know that I am practising safely within my limit then that is what is important to me..." (Midwife CBC04)

One independent midwife did suggest pushing the boundaries but remain within the context of safety:

“...if something was safe I would push the boundaries a bit, like extending the length of second stage from that stated in NICE guidance because the FHR was fine and the baby was advancing but slowly...” (Midwife INM01)

When asked to clarify what she classes as safe care, the interviewee discussed the health of the mother and a normal fetal heart rate but within the context of each individual case rather than a set guidance for every woman. She also discussed group reflection sessions with her independent colleagues to monitor her care and its safety.

Risk Management

Risk management is a component of clinical governance, which was born out of the need for real accountability for the safe delivery of health services. This was due partly to the public's and professionals' perception of systemic failings within the NHS. Clinical governance was defined in the 1998 consultation document, 'A First Class Service: Quality in the NHS (p93) and by Scally and Donaldson (1998) in a BMJ article as:

'A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'

Clinical governance including risk management is implemented to ensure safe, high quality care from all involved in the patient's journey and to ensure patients are the main focus and priority.

Interviewees' felt that guidelines and rules were used too much to manage risk and this detracted from them being used as guidance only and allowing individuality and autonomous practice:

“...I think it is that we are not encouraged to think for ourselves because I don't think that risk management kind of looks at autonomy...” (Midwife INM03)

“...But we are all continually reminded that you should not have done that or you wouldn't have had a leg to stand on kind of conversations...” (Midwife CBC02)

“...Because it is the management, they are desperately trying to put a lid on us by restricting choices to reduce the possibility of anything going wrong...” (Midwife INM04)

Yet, the literature states that professional autonomy is expressed by directing and monitoring practice:

“For a professional group, autonomy is expressed in the way it defines and directs its own sphere of practice provides appropriate education and monitors its members by a process of internal regulation without interference from others” (Kaufert, Glass, Freeman & Labine, 2004).

Flexibility

There was mixed feeling expressed with regard to the flexibility of rules and guidelines. Interviewees appeared to mix thoughts on rules and guidelines which were confusing as rules are there to govern practice whereas guidelines are used only as a basis for clinical practice. Some were positive towards them being guidance only:

“...I think they are flexible, to me they are a really good guidance and that is what I take them for...” (Midwife HFH03)

“...midwives rules as far as I am concerned give me enough scope to allow me to use my clinical judgement...” (Midwife INM04)

Some felt there was no flexibility to use them as guidance and that if they detracted from stipulated care they would be in trouble:

“...sometimes they don't allow us a bit of freedom with our guidelines and I feel I will be cautioned if I do anything against them...” (Midwife HFH02)

“...NMC doesn’t like autonomous practitioners, so when we practice autonomously and when we are doing stuff that challenges the norm, they hate it...” (Midwife INM02)

“...I always say rules and guidelines are there to guide you. Every person you look after is an individual so you have to change things a little bit but this goes against the normal practice here...” (Midwife TBC03)

There was also the thought from a manager within a midwife-led area that the word autonomy does not fit with rules and that for her working within the rules does not allow the freedom of autonomous practice:

“...I don’t like the word autonomously. I work within the rules and within what you expect to happen in this type of environment...” (Midwife CBC03)

Surprisingly, some midwives from the acute unit labour ward were neutral in their thoughts on rules; to the extent that some never thought about them. Perhaps this was due to the care they gave being prescribed by others like obstetricians and therefore they did not feel they were thinking for themselves or making decisions in the care of the women:

“...I have never thought about them really...” (Midwife TBC02)

“...I know about the rules and codes and I read them but I don’t really think about them...” (Midwife TBC04)

The Perception of the Characteristics of an Autonomous Practitioner

Within the literature it was stated that ‘autonomy is not merely a commodity it is a characteristic of individuals who are able to organise their lives in accordance with their own desires, plans and projects’ (Miller, 2001).

During the interviews the midwives described their perception of the characteristics that make an autonomous practitioner with regard to their professional knowledge, specific traits and the control a midwife has within their working practice.

Knowledge

In 1992, the UKCC published *The Scope of Professional Practice*. This document was widely regarded at the time as having liberated the development of midwifery from its previous reliance upon certification for tasks, towards an acceptance that it should be limited only by the individual accountable practitioner's own knowledge and competence (UKCC, 1992).

Interviewees felt that to be autonomous they needed the professional knowledge and the personal confidence with that knowledge to practise autonomously.

"...developing the skills to make to sure that you can practice autonomously..." (Midwife INM02)

"...If you get more confident in your skill then you have got the ability to be confident in your knowledge, you then have the confidence to be a bit more outspoken about it..." (Midwife HFH02)

This equates with what is stated in the literature by Cluett and Bluff (2000):

"The search for knowledge and understanding is integral to intelligent midwifery, epitomised by the midwife who is observant and sensitive, an effective communicator and a reflective practitioner."

A recently qualified midwife within the acute unit labour ward confirmed this by expressing concern that she had not reached this level of knowledge and therefore did not act as an autonomous professional:

"...I don't think I work autonomously because I think I don't have the knowledge. I would like to learn more..." (Midwife TBC01)

It is also stated that 'midwives possess a personal philosophy of care that influences their 'scope of practice' (Schuiling, Slager, 2000). A midwife's personal philosophy affects decisions related to the skills and practices she chooses to use, particularly those that may be new to her practice. A philosophy is stated to "ground midwives in their beliefs and serves to identify

tenets and hallmarks basic to midwifery practice (VandeVusse, 1997). However, while a midwife's personal philosophy is individual their professional practice should be incongruent with that of the NMC. It is questionable, however, whether midwives will have a personal philosophy and most will not know the unit philosophy.

Some interviewees felt they had the professional knowledge already and verbalised how they use that skill and knowledge in their autonomous practice:

"...I see it as the fact that I have the knowledge and the confidence to act, to take responsibility for my actions..." (Midwife CBC02)

"...Autonomy means making decisions and choosing courses of actions based on your experience as well as your intuition or your desire..." (Midwife HFH05)

"...It's about being well informed to be able to make the decisions for myself on my own head if you like..." (Midwife INM02)

Traits

Within the literature autonomy was described as "not merely a commodity but a characteristic of individuals who are able to organise their lives in accordance with their own desires, plans and projects (Miller, 2001)." Interviewees described their own views of the most significant characteristics or traits that an autonomous practitioner would have.

Many interviewees referred to autonomous midwives as having confidence or being confident:

"...you have to be confident to really be autonomous..." (Midwife TBC02)

"...I am a confident person and that is what is needed to be autonomous..." (Midwife TCM04)

Within the literature this was stated as being attitudinal autonomy or as 'having the self confidence to take appropriate decisions and to be prepared to accept any consequences which may ensue' (Vaughan, 1989).

A community midwife also believed that just appearing confident rather than necessarily having confidence could also portray an individual as autonomous:

"...I look confident, so I appear to be autonomous..." (Midwife TCM03)

Confidence was also portrayed through the ability to speak your mind and 'fight your corner':

"...you need to be proactive and you need to be forthright and articulate..."
(Midwife CBC05)

"...assertive and strong to be able to fight for what is right..." (Midwife INM03)

But in complete contrast to this, interviewees stated that an autonomous practitioner was also seen as having motherly, nurturing traits and patience. This did not appear within the literature as an aspect of an autonomous person but as it appeared frequently throughout the data I felt it was important to this study. My thinking here is that the interviewees were describing a general trait of a midwife or personal traits rather than a specific trait of autonomy:

"...sort of chubby and big earrings, long skirt and quite sort of motherly and buxom breasted. Yes very kind of motherly..." (Midwife CBC01)

"...being able to nurture somebody..." (Midwife HFH03)

"...you have to have patience and understanding..." (Midwife HFH01)

In contradiction was the view that the autonomous professional was seen as a loud, bossy, outspoken person not afraid to give an opinion:

“...I am very black and white and outspoken and I am not afraid to have my opinion if I think it is required...” (Midwife HFH02)

“...I think anyone can be an autonomous midwife if they are noisy, loud, extravert and dominating...” (Midwife HFH05)

“...usually they are bolshy people...” (Midwife TBC02)

Such a variance in the traits of an autonomous practitioner could be noted as an area for further research ensuring clarification between personal traits, those of a midwife in general and those of an autonomous practitioner.

Control

Another aspect of the perception of an autonomous practitioner reported by the interviewees was that of control. Beauchamp and Childress (2001) acknowledge personal autonomy as being, at a minimum, self-rule where the individual is in control of their own life and free from both controlling interference from others and from limitations, such as inadequate understanding, that can ultimately affect making meaningful choices and decisions.

Interviewees described control within decision-making and having responsibility for the care of the woman:

“...Autonomy means to me that I am able to make my own decisions, to be in control and express my own ideas and values...” (Midwife HFH04)

As well as being able to work alone and not be beholden to others as was stated by Clark 2004, Jowitt 2000 and Donnison 1988: ‘professional groups have been concerned with maintaining control which has consequently continued to affect the extent of the midwives autonomy to make her own practice decisions:’

“...You are responsible for what you are doing. You don’t follow anyone else’s advice you are working as an individual practitioner...” (Midwife TBC05)

“...I don’t need somebody else to tell me what to do. I have the knowledge to work it out and act on it myself without being beholden to somebody else other than the woman...” (Midwife CBC02)

Both of these interviewees clearly described their individual accountability and showed confidence within their practice which relates to autonomy.

For independent midwives it was that their own autonomy allowed the women they cared for to have control over their own care:

“...I am also a control freak but I want everybody to control their own destiny and to be strong enough to say yes and no with the information that they have got...” (Midwife INM05)

“...working closely with women and giving them the autonomy of their decisions...” (Midwife INM02)

The Effect of the Relationship Between Midwives and the Women, their Colleagues and Employers

This theme concentrates on the political environment of the NHS where the high numbers of women moving through the system and change management has an impact on midwifery practice. It also looks at women’s autonomy on midwifery practice, through midwives being an advocate for women to the aspect of the woman’s own autonomy impacting on midwifery autonomy. Then finally discusses how differing relationships between colleagues and employers can impact on midwives autonomy.

Politics

Interviewees discussed the ability to practice autonomously within a political environment like the NHS, in particular the lack of support within change management, the shortage of staff and high workload. Within the literature Hunt and Symonds (1995) discuss the cultural context of midwifery practice in the NHS with the industrial influences of shift systems, line management, production targets and the attempts to regularise an unpredictable work pattern:

“...I think it’s very political in the NHS, too many managers who have no idea about clinical practice in a stressful environment...” (Midwife HFH02)

This is a broad accusation, it is impossible to group all managers together as acting the same. As midwives themselves have different working practices’ so do managers, some will clearly continue to have clinical input, even though it may be a small percentage of their weekly workload and job description.;

Other interviewees expressed “within that environment of non-individualised care it is impossible to act the way you want to... (Midwife INM04)

“...I always used to get into trouble for suggesting things because they were so resistant to change here...” (Midwife CBC05)

“...I don’t think there is much support now because of the shortage of staff...” (Midwife TBC03)

Women

Heagerty (1997) relates that while the Midwives Act 1902 provided the power to reform midwifery practice it also affected the mother-midwife relationship because her loyalty was to the profession. However, interviewees working within the midwifery led birth centres and independent midwifery expressed that having autonomy was being able to empower the women to have autonomy in their care, which means placing their loyalty to the woman as a priority over their profession. This was a specific aspect of independent midwifery care:

“...I have given somebody the power for them to take control and that makes me feel brilliant. I am giving the women the options to make informed choices...” (Midwife INM03)

“...It is a way of letting the couple make the decision from all the information you have given them...” (Midwife INM05)

Although the 'Winterton Report (1992)' and 'Changing Childbirth Document (1993)' preferred the words 'choice' and 'control', they provided answers to the question of the needs and wishes of both the woman and the midwife with regard to autonomy. This was clarified by interviewees:

"... all we are doing is enabling and empowering women to make choices as I was enabled and empowered to have my babies..." (Midwife INM04)

"...I don't see them as being my decisions it is the couples decisions. Is it my autonomy? No it is her autonomy..." (Midwife HFH05).

It has been reported that where the woman is the central decision-maker in matters relating to her care; autonomy is established (DOH 1993). Interviewees felt that if the woman was articulate and educated, about the care they wanted, this forced the midwives themselves to exert their own autonomy within the care that they gave:

"...Women who have had higher education and high powered jobs, they tend to have a bit more of say in what they do and don't want. I notice the difference in my care with them..." (Midwife TBC04)

"... Some women want to do things a bit more differently or they want different things themselves; that makes me think differently about what I do..." (Midwife TBC05)

"...the majority are quite strong women and they will to turn round and say because they have expectations of what they want from me..." (Midwife HFH03)

Amongst the independent midwives there was a feeling that women selected the independent midwife for their autonomy in being able to practise continuity and not afraid to offer individualised care. Etzioni (1975) stated, 'within independent midwifery the midwife is fully accountable to the woman who is employing her alongside her professional accountability:'

“...I think that some of the women that contact me who would just like a midwife who will be with them all the time, that they know, who is not under hospital guidance...” (Midwife INM03)

“...they want to find someone who is not afraid and who will support them in what they want and so they look for the midwife with autonomy...” (Midwife INM05)

“...there are always the women who are doing it because they are frightened of the alternatives, they need that independence from the system and that to me means autonomy...” (Midwife INM02)

Colleagues

The United Kingdom Central Council (UKCC, 1997) stated that ‘The active support of employers, managers and colleagues is vital to the successful implementation of the principles of the scope of practice’.

This area of the study looks at the relationship between midwives and members of the multidisciplinary team, including managers, obstetricians and peers and the impact of this relationship upon autonomous practice. Perceived barriers to midwifery autonomy include lack of recognition for the midwives’ professional role, lack of professional confidence, the impact of midwifery education, the context of the working environment and the dominance of the medical profession (Meerabeau et al 1999, Meah et al 1996, Hosein 1998). This was supported by interviewees who stated if they were supported by their colleagues they felt encouraged to practise autonomously:

“...How people treated me as well and what information they gave to me, it helped me in my practice...” (Midwife INM02)

“...I find they all have an ear to listen to you and that they are really generous with their support for you. They always ask what you think...” (Midwife TBC04)

This was also justified by the opposite experiences of interviewees who were unsupported by other midwifery colleagues and this affected their own autonomy:

“...senior midwives are not supportive, they are not respectful. They are not respectful of other midwives so they are not respectful of me and what I do...”
(Midwife HFH04)

“...It really irritates me when other midwives treat other midwives in a very patronising way because they are practising individually...” (Midwife HFH02)

However, it was not just midwifery colleagues who impacted on their autonomy but medical colleagues as well. Within the House of Commons Health Committee report (1992), it was recognised that there was interprofessional rivalry between midwives and medical colleagues. As professional groups have historically been predominantly male- for example, medicine and law- such groups have been concerned in maintaining control which has consequently continued to affect the extent of the midwives autonomy to make her own practice decisions (Clark, 2004, Jowitt 2000, Donnison 1988,). This was also expressed by the interviewees:

“...I feel that generally in the team you do have a certain level of autonomy but because the doctor’s work in a specialist area, they basically write a recipe and you follow it...” (Midwife TBC04)

Yet this is in conflict with other studies that suggest that ‘whilst midwives appear determined to be thought of as autonomous practitioners, their medical colleagues now appear more willing to allow them to practise autonomously (Marshall & Kirkwood, 2000). This also poses the question that autonomy is associated with being allowed to act in a particular way rather than being a commodity of an individual as literature states and discussed earlier.

Also the interviewee’s statement does not agree with what was to be achieved by the introduction of Interprofessional Team Objective Structured Clinical Examinations (ITOSCE’s). This concentrated on the sharing of

common and core skills and was highlighted as a way of gaining a better understanding of different health professional roles and enables decisions to be made together and recognise the full extent of each others role (Symonds et al. 2003).

How the Potential for Role Confusion between Statutory Supervision and Management of Midwives impacts on Midwifery Practice

The important aspects of supervision include the search of one's own professional identity and the awareness of the possible and actual professional roles, as well as the responsibility and commitments accompanying those roles (Kobolt and Zorga, 1999).

While supervisor's duties are prescribed, there is a wide variation in the manner in which they are discharged. In a study of supervision in England, Stapleton found 'little evidence of a coherent model of practice' (Stapleton, 1998). This section discusses the impact of supervision versus management of midwifery practice with particular relevance to support or restriction of practice as well as the aspect of self support and practice development and how all of these relate to midwifery autonomy.

Support

Supervisors see the protection of the public as their function and this is consistent with national legislation (NMC, 2002). Midwives, in contrast, believe the provision of professional support is the supervisor's most important role (Kirkham, 2000). This was supported by interviewees who described the support they received from their supervisors as an important and positive aspect of supervision in encouraging them to practise autonomously.

"...I have got a very supportive supervisor, exceptionally supportive and that is fantastic..." (Midwife INM03)

“...I would use my supervisor. I have a very good relationship with her. She is a friend and she is colleague and I trust her implicitly with anything regarding work...” (Midwife CBC04)

“...I would use the supervisor, the support is fantastic and I feel that I can always go to her...” (Midwife TBC04)

For the independent midwives they felt they had support from supervisors but had specific ideas about what made a good supervisor for their specific needs. This would agree with the literature which stated that ‘these midwives hold quite different expectations of the supervisory function and appeared more pragmatic with regard to the limitations of the supervisor’s role.’ (O’Connor, 2002):

“...She is also good at giving me a shove when I need it, which is good because I don’t want someone who won’t and I don’t want someone who will squash me either...” (Midwife INM02)

“...the perfect person to be a supervisor because she knows us and she trusts us you know there was a very strong mutual respect, which is a really nice, nice feeling...” (Midwife INM04)

Working outside the NHS with different working patterns the norm rather than the exception; independent midwives are less threatened by supervision (Fraser, 2002). An independent midwife viewed the supervision positively with regard to support but that this support came without the knowledge of independent practice and the different working practice outside the NHS.

“...So yes she was very supportive although she had not got a clue about independent midwifery...” (Midwife INM05)

This disagrees with the study in Ireland by An Bord Altranais (1999a): ‘Independent midwives are, however, dissatisfied with the supervision arrangements that exist.’ This would suggest that independent midwives and supervisors have developed and improved their working and supervisory relationships since 1999.

Some midwives discussed the aspect of managers acting as supervisors as not being an issue. However, stating that clear boundaries are needed when separating management and supervision.

“...She is also a supervisor and also a manager so she has her boundaries but she makes them explicit and we understand why they are there...”
(Midwife CBC01)

“...There is a manager, supervisor on the labour ward who is very, very supportive and you can call on her and she is willing to listen, which is good...” (Midwife TBC03)

This is a view that is also stated within the literature:

“There is also a concern that supervision, which is statutory in nature and linked to a management function, may not be conducive to the open and frank communication that is necessary for clinical support.” (An Bord Altranais, 1999a).

Another aspect of having management as supervisory support compared to a clinical midwife was the impact the manager had on organisational change and the remit to offer effective support from their hierarchical position. This view was supported in the literature by Kirkham (2000), *‘whilst a non-manager was likely to be seen as trustworthy in terms of support and confidentiality, they usually lacked the organisational power to act as an effective advocate for midwives.’*

“...Our manager is a very good manager and you would certainly want her on your side put it that way...” (Midwife CBC02)

This statement came from a stand-alone birth centre midwife where the area of practice is within a small unit and where midwives have a closer working relationship with managers who are also supervisors. It is possible that this viewpoint may not be the same for midwives practising within an acute trust where midwives do not work so closely with their managers and supervisors;

however they did not vocalise this during the interviews. Notably within the literature Yegdich (1999) asserts: 'Clinical supervision can only function on a foundation of managerial supervision, staff welfare and support, and education. It is achieved by the fact that managerial supervision already occurs, a fact that midwives should take for granted.'

Restrictive

It emerged from the interviews that some midwives have difficulties in gaining access to individual supervisors and this led to not feeling supported and therefore had a negative impact on them practising autonomously. The interviewees felt less likely to practise autonomously without the benefit of supervisory support:

"...If I want one I think there is one down the corridor but I called the supervisor twice and she said she would contact me and I am still waiting..."
(Midwife TBC01)

"...the last few times that I have arranged to see her she didn't turn up. I don't feel that she would offer me the kind of support I want..." (Midwife HFH01)

"...I have emailed my supervisor once or twice this year but not seen her. She is higher up in the hierarchy now so it must be really hard for her..." (Midwife TBC02)

Another aspect of restriction was that of muddling management and supervision and the interference of managers rather than the support of supervision as discussed within the literature, 'sometimes this is felt to result from the supervisor confusing her responsibilities and attempting to manage rather than supervise' (Berman, 2000, p273-290). This was particularly noted by the independent midwives:

"...Sometimes it is someone you don't know and in that particular case they don't know if they are the manager or the supervisor and then they get terribly muddled..." (Midwife INM03)

“...I have real issues if they are going to say you can be autonomous then they need to respect that and stop managing and support us...” (Midwife INM02)

Interestingly a stand-alone birth centre midwife felt that management interfered in supervision, by closely monitoring individual practice, which is in contrast to the earlier viewpoint, from the stand-alone birth centre midwife, who felt a manager as supervisor was beneficial due to her hierarchical position and capability to be advocate for the midwife:

“...I do think that sometimes managers interfere in supervision, they “police” our practice for the wrong reasons...” (Midwife CBC05)

The ‘policing’ dimension has invariably been a dominant influence and this aspect of supervision continues to be a very problematic area causing tension for some practising midwives and supervisors (Walton 1995, Leap and Hunter 1993, Kargar 1993, Flint 1985). It is possible that the interviewee statement came from a personal negative interaction with her supervisor/manager that has not been resolved rather than a conclusive view of all the midwives at the stand-alone birth centre as no other interviewee from this practice area discussed this issue.

Self-Development

Since 1936 there has been a statutory requirement for midwives to update themselves professionally. Initially this was prescribed but over time more flexibility was included until in 1995 it became a completely flexible practitioner-led process that applied to nurses and health visitors as well. Therefore each practitioner has the responsibility to maintain her continuous education and develop her practice, it is not a prerequisite of supervision. Supervision merely safeguards the evidence of Post Registration Education and Practice (PREP) by checking personal PREP files annually with the midwives they supervise.

However, interviewees discussed the aspect of self-development with negativity, expressing a view that supervisors should be more supportive by

actively encouraging them in development of their skills and organising individual education and development programmes, as well as chasing midwives to attend supervisory meetings:

“...Supervision, I find that it is very much on your own back to make sure you get support...” (Midwife HFH02)

“...on a one to one basis to make sure that you are OK, I think it is very much up to you get your supervision and update yourself ...” (Midwife TCM02)

Yet to be autonomous is to be ‘self-directed’ so these midwives could be seen as not autonomous by nature or in professional practice.

Notably one independent midwife did express a view that if she was unhappy with the process of supervision she would actively seek out an alternative and pursue this to resolve the problem;

“...if I experience poor supervision it is my responsibility to do something about that rather than avoid it...” (Midwife INM02)

Perhaps this was more common-place amongst those practising within a self employed capacity where midwives are used to seeking out information from other professionals and alternative ways of working and are very aware of the process of supervision with working alone outside of the NHS and occasionally feeling scrutinised as supported by the Kirkham:

“Direct observation of practice continues to form an integral part of supervision for self-employed midwives, at least in England, while a disquieting trend towards the scrutiny of personal attributes rooted in subjectivity, such as ‘attitude’, has been noted (Kirkham, 2000)”.

How Fear Impacts on Midwifery Practice

This area of the study looks at aspects of the interviewees work that they felt caused fear or anxiety and affected their daily practice within the areas of

being employed and litigation. It also explores the trait of being confident in reducing the fear of practising autonomously.

Employer

There was a negative attitude from the midwives towards being employed with a view that midwives were caught between how they wanted to practise and how they felt they should practice for the employer. Stafford (2001) stated that 'midwives feel the tension between what they are trained to do and what they are asked to do. They may also face conflict between their professional accountability and fulfilling the requirements of their employers.

"...If you do one thing you are going to be sacked, if you do the other you will be struck off..." (Midwife INM05)

"...The establishment will come down on you like a ton of bricks..." (Midwife CBC05)

"...I wish I could say not barred by the Trust but there is that element that they employ me which I find underlines my autonomy..." (Midwives CBC01)

Etzioni (1975) demonstrated the use of accountability as a ploy in the power politics of healthcare. He shows that the more powerful an occupational or professional group becomes, then the more others are accountable to them. This could be seen as equating to the powerful organisation of the NHS.

Litigation

Litigation is an increasing aspect of modern health care, and midwives are not immune from investigation or complaints (Walsh, 2000). Interviewees were asked about their fear of litigation and whether litigation might impact on their practice. What emerged were two opposite thoughts where some felt that if you practise safely then this should not be an issue:

"...if you fear litigation then you probably shouldn't be a midwife..." (Midwife HFH01)

“...I think if you think you are practising safely, you are not doing something reckless why should you fear litigation...” (Midwife HFH04)

“...I am not looking at the book all of the time or constantly thinking I might be breaking a law here...” (Midwife INM03)

On the other hand there were midwives who worried about litigation to the extent it would impact on their professional practice:

“...It is not the client that worries me it is the ombudsman that is protecting us that worries me...” (Midwife INM05)

“...I think it does influence what you do. It is always an underlying factor...” (Midwife TBC04)

“...It worries me about complaints, about me not practicing correctly; it makes me nervous about my care...” (Midwife TBC05)

Between both of these viewpoints was the thought that making mistakes and litigation was to be expected when working in midwifery:

“...I think midwifery is so predictable and I think that you have to accept in midwifery things do go wrong...” (Midwife HFH04)

“...everyone makes mistakes and can't practice they way they want to all the time...” (Midwife TBC05)

Confidence

It was previously discussed that confidence is seen as a trait of the autonomous practitioner, confidence was also seen as a requirement to be able to practise without fear:

“...I see it as the fact that I have the knowledge and the confidence to act, to take responsibility for my actions and not fear the aftermath of my decisions...” (Midwife CBC02)

“...If it is not how you do it in a text book then you need to not worry and have the confidence as a midwife and say this is a little bit outside the guidelines...” (Midwife HFH04)

“...You have to know your strengths and your weaknesses, not to fear asking for help or when to involve someone else...” (Midwife TBC03)

What Defines the Freedom to Practice Autonomously?

Vaughan (1989) observed: ‘some people have interpreted autonomy as meaning total freedom to act’ (p159-165). Interviewees discussed aspects of their midwifery practice that allowed them, or not, to practice autonomously with particular reference to protocols, practice area and decision-making skills. The impact of work systems like the NHS versus private practice also appeared as a factor to determine the freedom to practice autonomously.

Protocols

There was a common issue surrounding hospital protocols, where they were said not to allow the freedom to practise autonomously but more of a law to abide. This appeared across all areas of practice covered by the interviewees:

“...The hospital policies are much more restrictive because they are usually based on how the hospital wants you to look after a particular woman...” (Midwife HFH02)

“...because it is high risk; there is really not any autonomy and making decisions outside the box...” (Midwife TBC02)

“...I think the guidelines are not really guidelines but what you have to do...” (Midwife HFH01)

However, no midwives discussed being actively involved in the process of writing and updating guidelines despite being very negative to their usage. The literature stated that ‘within the major units, policy-making was medically controlled, as previous studies have found (Garcia & Garforth 1991, Meah et al. 1996) and in the study by Pollard (2003) in the low-risk units, policies went

to the medical staff for 'comments' or for agreement. There was little agreement about the amount or quality of midwifery input into policy-making. Some respondents, who thought they practised autonomously, played a part in drawing up guidelines or said they did not follow policy when they considered it clinically inappropriate. It could be seen then that the interviewees were restricted in practising autonomously when not involved in the guideline process.

Interviewees from the stand-alone birth centre felt policies were restrictive although there was a realisation that the one's they followed were less restrictive than other hospitals:

"...it is the local policies and guidelines that are restrictive but I am very aware that they are quite lenient compared to some..." (Midwife CBC02)

Autonomy is seen as having the ability to make decisions and act on an individual basis without feeling restricted by policies. This was expressed not only by independent midwives but those working in hospital midwifery led units:

"...I suppose it is being able to practice in circumstances where you are not compromising what you are doing because of some hospital policies or protocols..." (Midwife INM04)

"...having the ability and confidence to make decisions about the woman's care and having the flexibility rather than tied by the hospitals guidelines or protocols..." (Midwife HFH02)

Independent midwives felt that autonomy was specifically having the freedom to offer individualised care rather than that which is based around guidance for mass numbers of women as is the case within the NHS:

"...giving her all the information that she wants and/or needs and working with her without being constrained by inappropriate protocols that don't apply to that individual..." (Midwife INM04)

“...So it is very much about individuality. You know being able to meet needs of individuals rather than great masses, which protocols do...” (Midwife INM02)

This is supported by Williams (1994), “others have direct input into their written policies which, within their practice guidelines, leaves room for exercising judgement and have somewhat flexible boundaries in reference to “scope of practice”.

Independent midwives do not have guidelines for everyone to follow as a group therefore each midwife works to their own guidance within individualised care of their women. This may offer more flexibility and scope for their care of women and could be seen as a reason for a woman choosing an independent midwife. However, how each individual midwife decides on their own guidance and what parameters each midwife has for safety will vary, this poses a problem of inconsistent practice for women opting for this type of care and is an unknown entity for supervision and the NMC.

Decision-Making

The professional autonomy of the health professional is associated with the freedom they have to make decisions consistent within defined boundaries of their clinical practice, together with the freedom to act on those decisions (An Bord Altranais, 1999). The midwife, therefore, by the nature of statutory legislation is solely responsible for making decisions in relation to maternity care within the context of normality (NMC, 2004).

Interviewees felt that being able to make the decisions with women on the care given was an element of acting autonomously, whether this was being able to within their working environment and/or having the knowledge and skills to do so. Notably this was not commented on by the acute unit midwives but by all midwives from other areas of practice

“...I think autonomy would be caring for the woman, making most of the decisions that you feel are right...” (Midwife TBC03)

“...Autonomy means to me that I am able to make my own decisions and express my own ideas and values...” (Midwife HFH04)

“...it’s about being well informed to be able to make the decisions for myself on my own head...” (Midwife INM02)

It was also felt that within the community setting and in areas, like the integrated birth centre, where there were no obstetricians, the freedom for decision-making was more prevalent:

“...As a community midwife I think you are autonomous because you are working on your own and you do make a lot more decisions on the woman’s care...” (Midwife TCM05)

“...There are no obstetricians hovering around and you are left to make your own decisions...” (Midwife HFH04)

As professional groups have historically been predominantly male; for example, medicine and law, such groups have been concerned in maintaining control, which has consequently continued to affect the extent of the midwives autonomy to make her own practice decisions (Clark, 2004, Jowitt 2000, Donnison 1988).

Practice Area

Interviewees participating in the study worked within the NHS and private independent sectors of maternity care. Those within the NHS worked either in a stand-alone birth centre, integrated birth centre, acute unit labour ward and community settings. A number of interviewees felt they could only practice autonomously within the community, although notably not a viewpoint specifically expressed by any of the community midwives:

“...I think autonomy is a misnomer and the people who come close to autonomy are people who work in the community...” (Midwife HFH05)

“...community based. I strongly feel that is where you are mostly autonomous...” (Midwife INM02)

“...there is not as much autonomy as in the community where you make your own decisions...” (Midwife TBC03)

To confirm this opinion midwives discussed that the hospital environment was not conducive to autonomous practice:

“...I actually find that in a hospital I have no autonomy...” (Midwife INM03)

“...I think in a hospital environment you are really quite restricted...” (Midwife TBC01)

In contrast to both of these opinions was that a stand-alone birth centre midwife felt this was the same for this midwifery-led environment as well which may be seen as a controversial statement and it could therefore be assumed that this was an individual view rather than a consensus of opinion:

“...don’t think that autonomy actually fits here, in the birth centre, if you used the word properly...” (Midwife CBC03)

Work Systems

In 1993 Jean Ball drew midwives attention to the difficulties of implementing the Winterton proposals within the mechanisms and constraints of the internal market system of the NHS and Tew (1995) stated that in historical terms, the major organisational development which affected the midwife’s accountability was the introduction of the NHS in 1948 (Tew, 1995). Midwives themselves felt that their scope of practice decision-making was centred on the way in which health services were delivered (UKCC 1997)

Interviewees from the midwifery led care areas of practice within the study felt that that the NHS system was a main issue surrounding the ability to practice as an autonomous practitioner rather than the way the profession led midwives to practice. In particular the self-employed midwives explained this as reasons why they practise independently:

“...you don’t have autonomy in the NHS and that was a big thing I could not come to terms with...” (Midwife INM05)

“...The system of midwifery care in this country, within enormous hospitals systems, cannot deliver as much as individual practitioners...” (Midwife INM04)

Interviewees practising within the stand-alone birth centre and integrated birth centre also felt restricted working for a large organisation such as the NHS:

“...no choice in our care of women, that is part and parcel working for the NHS...” (Midwife CBC02)

“...I think the problems are more NHS based rather than as a profession...” (Midwife HFH02)

This was a view supported in the literature by Bradshaw and Bradshaw (1997) who suggest that ‘midwives remain controlled more by organisational rules and regulations than by autonomous decisions’.

How Midwives Measure Autonomy within the Work Environment

This theme covers aspects of a midwife’s practice that are then used by them to measure the extent of their own autonomy. It involves their experience of and type of professional education as well as their experience through their midwifery career. It looks at their accountability and the link with autonomy and how guidelines within their working area can affect the extent to which they practice autonomy. How midwives measure autonomy is linked with their understanding of autonomy as discussed within the earlier theme of the perception of an autonomous individual and professional.

Education

The effectiveness of midwifery education with regards to competency is well documented however it is Pollard’s (2003) study that interestingly found that midwives educated via the direct-entry route were perceived to be more

capable of exercising autonomy in practice decisions than the nurse trained midwives. Notably direct entry interviewees felt their training developed confidence and competence in aspects of autonomous practice:

“...tutors really did encourage us to question...” (Midwife CBC02)

“...the majority of teaching made us think for ourselves...” (Midwife INM02)

“...I had a good training and that is what gave me the confidence...” (Midwife TCM02)

Although one direct entry interviewee and one eighteen month post registration interviewee felt that the learning came post qualifying, this relates to the model by Benner (1994) which described the potential development of nursing expertise as progressing through five stages from novice to expert with stage one being the novice with little or no experience:

“...But then I learnt an awful lot more once I qualified as well. Just from different midwives and just from how women behave as well...” (Midwife TBC05)

“...I know that your confidence does build up after you have been working on your own for a bit although I was pretty much prepared from my learning...” (Midwife TBC02)

Hence, being able to extract from prior experiences highlights the concept that midwifery experience is crucial for the development of expert skills and collaborating with this, autonomy itself.

Following on from this some interviewees felt the issue lies before qualifying with the midwifery education as a whole. Whether direct entry education or not, interviewees expressed a view that the education system needed changing to accommodate and encourage autonomous practice:

“...I think it is very important for midwives to practice autonomy and education. I think we should rewrite the curriculum completely...” (Midwife CBC01)

“...in order to have better midwives you have got to have better education and I am dam sure I could do a better job then they are...” (Midwife CBC02)

“...I did a lot of research because I felt I was being told things I did not necessarily agree with and I wanted my own autonomy...” (Midwife INM05)

Experience

In 1992, the UKCC published The Scope of Professional Practice. This document was widely regarded at the time as having liberated the development of midwifery from its previous reliance upon certification for tasks, towards an acceptance that it should be limited only by the individual accountable practitioner's own knowledge and competence (UKCC, 2000).

“...Autonomy means making decisions and choosing courses of actions based on your experience...” (Midwife HFH05)

“...I am sure that your experience as a midwife will definitely determine whether or not you use the guidelines as protocols or guidance and is a prerequisite to being accountable...” (Midwife HFH02)

“... a person who has knowledge, skills and training and using their skills to their best of their ability...” (Midwife TBC04)

Varney, 1997 states: “scope of practice” evolves and changes over time due to a number of variables including community needs as well as the midwife's philosophy, education and years of experience, government laws and national standards and the policies and procedures of the hospital or institution itself:

“...I like to think for myself but I think with experience I could work further outside the guidelines...” (Midwife TBC01)

“...I don’t think I work autonomous because I don’t have the knowledge. I would like to learn more...” (Midwife TBC01)

Accountability

Etzioni demonstrates the use of accountability as a ploy in the power politics of healthcare. He shows that the more powerful an occupational or professional group becomes, then the more others are accountable to them. Although this is a cynical viewpoint there is an element of truth within midwifery practise, during recent years, as midwives become more vocal in maternity care and increase autonomy within their professional practice within roles such as Consultant Midwives posts. This assists in promoting the midwifery profession as a powerful group amongst other professionals which also increases their own and others accountability to them. Greenfield (1975) maintains that accountability incorporates decision making at the time of the activity and the potential for justifying decisions and actions at a later date. Accountability, therefore, may be seen to be about decision-making (Jones, 1994). This was view also expressed by interviewees:

“...You are responsible for what you are doing. You don’t follow anyone else’s advice you are working as an individual practitioner...” (Midwife TBC05)

“...It would be one where I make the decisions. The buck stops with me...” (Midwife CBC01)

In ethical terms the main form of accountability to carry any weight for midwives is their accountability to themselves. Jones (2003) indicates that this form of accountability is an unalterable fact of care. Caring according to one’s own philosophy of life and acting consistently according to the demands set by one’s own value system may call for a different standard of care than that required by any external agency. This was also in agreement with interviewees:

“...Autonomy is having the ability to admit that I don’t know and to be autonomous enough to refer to someone else...” (Midwife CBC01)

“...I have always done my own thing and taken responsibility for myself...”
(Midwife INM02)

In contrast to this an interviewee from the stand-alone birth centre expressed concern with taking responsibility for actions when working within an area of a larger organisation:

“... to be responsible for your entire practice here makes me uncomfortable, I feel I am being controlled by a bigger force...” (Midwife CBC02)

A view, in agreement with Etzioni (1975), who stated ‘the hierarchical organisational structures within which midwives continue to work serve only to diminish their accountability.’

This relates to the perception of midwifery accountability from other professionals. Walker’s work showed that midwives understood the extent to which they were accountable but that their medical colleagues were less clear about midwives and their role. Interviewees within the acute unit labour ward, who had the most contact with doctors from all the practice areas used in the case studies, also described these difficulties when working with obstetricians:

“...There was a complication yesterday and the doctor wanted to do every test going but there was no reason to. I tried to speak to him but he would not allow me to say anything...” (Midwife TBC03)

“...Generally in the team you do have a certain level of autonomy but because the doctors work in this specialist area, they basically write a recipe and you follow it. They don’t understand we have a view on care...” (Midwife TBC04)

Both of these interviewees worked within the acute labour ward setting where the majority of women were high-risk cases requiring obstetric input. Their statements would seem a little contradictory, in that, if there is a complication an obstetric view would be sought and further action taken, therefore it would not appear to be a situation warranting midwifery questioning or debate. Perhaps

they were merely attempting to advocate for certain aspects of the woman's care but as midwives are both professionally and legally accountable for their actions as Cox (2000) points out, the emphasis here is that there may be a price to pay for accountability. This price is the cost of taking risks, personally, professionally and organisationally, and accepting the consequences of our own actions. Risk taking is an essential part of learning and the personal growth which ensues. Midwives need to ensure they are acting within the realms of normality and advocating within these limitations.

Guidelines

National and local Trust policies and procedures affecting maternity care may enable or inhibit the midwife to make autonomous decisions. This is dependent on the guidelines being formulated with midwifery input. Jowitt (2001) stated that the National Institute for Clinical Excellence (NICE) guidelines affecting midwifery practice have been developed based on obstetric and paediatric principles rather than midwifery ones.

This was not a general view expressed by interviewees who stated that guidelines were there to assist in care and that they did not detract them from acting autonomously or offering individualised care:

"... I work under the guidelines of the hospital and probably follow the NMC guidelines but I don't think that it does not make you autonomous..." (Midwife TBC05)

"... at the end of the day they are just guidelines and if I want to question the guidelines then it probably furthers my thinking..." (Midwife HFH03)

"...The reason that I think that they are a big help is that they are so woolly and so grey and that is fabulous..." (Midwife CBC01)

Other interviewees had midwifery input into their guidelines which was found to be beneficial. A view in agreement with the literature which states that 'direct input into written policies which, within their practice guidelines, leaves room for exercising clinical judgement and have somewhat flexible boundaries in reference to "scope of practice" (Williams, 1994):'

. “...We are quite lucky where I work because the guidelines are midwifery led first and then they change, this gives us leeway to practice individualised care and act with autonomy... (Midwife CBC03)

Discussion

The following section discusses the key issues that emerged from the data surrounding autonomy and the midwifery profession to ascertain if midwives understand the concept of autonomy and what is required to ensure the midwifery profession continues to maintain its autonomous status.

The central issue appears to be whether midwives want to be autonomous practitioners? The data here suggests that this is debatable and alongside this there appears to be no set definition amongst midwives for autonomy as there were mixed views among interviewees about the basic concept of autonomy and what constitutes an autonomous person/professional.

Midwives felt that to be autonomous they needed the professional knowledge and the personal confidence with that knowledge to practise autonomously; referring to autonomous midwives as “having confidence or being confident”, known within the literature as attitudinal autonomy. Hence, being able to extract from prior experiences highlights the concept that midwifery experience is crucial for the development of expert skills and collaborating with this, autonomy itself.

Alongside this it was seen as crucial that midwifery education programmes were developed to encourage confidence and competence in aspects of autonomous practice. Although it appears that education is a key issue, both within the profession itself, among NHS management and other relevant professional groups. Education about the extent and detail of midwives’ professional obligations would be required for midwives, NHS management and the medical profession; some doctors still interpret a midwife’s mandatory referral for abnormality as an unwillingness to take responsibility for clinical decisions (Meerabeau et al. 1999). Prequalifying education would also need examining as there is an assumption that midwives are equipped for autonomous practice (Robotham, 2000); this is contradicted by the data

and means midwifery educators may need to explore the students understanding of autonomy.

In complete contrast to this an autonomous practitioner was also seen as having motherly, nurturing traits and patience. Although not seen within the literature as an aspect of an autonomous person because it appeared so frequently throughout the data it could be viewed that either, perception of what constitutes an autonomous professional has changed over the years or most likely that midwives were describing a general trait of a midwife or personal traits rather than a specific trait of autonomy.

Such a variance in the traits of an autonomous practitioner could be an area for further research ensuring clarification between personal traits, those of a midwife in general and those of an autonomous practitioner.

In parallel with these mixed views about what constitutes an autonomous professional was that midwives also did not understand the extent of their role and questioned whether they actually practised autonomously. A huge factor affecting this was whether they were caught up with hierarchy and obstetric control and was dependent on practice area.

Experiences of midwives varied between each practice area and the work culture within these environments impacted upon their autonomous practice. It was also said to be dependent on the characteristics of other health professionals within those environments and how many other people the midwives dealt with on a daily basis. It can be seen that there is no greater barrier to autonomy than one's own peers.

Midwives noted that within a hierarchical structure there is an element of negotiation with colleagues for the midwives to maintain their own autonomy when caring for a woman. This was reported across all areas of practice, but mainly referred to obstetric colleagues rather than midwifery. This relates to the perception of midwifery accountability from other professionals. Walker's work (1999) showed that midwives understood the extent to which they were accountable but that their medical colleagues were less clear about midwives and their role. This was seen within the acute unit labour ward, where

midwives had the most contact with doctors and described these difficulties when working with obstetricians. However, in the absence of such hierarchy autonomy between midwives was said to improve, although not all midwives utilised this and recognised their own autonomy and a large proportion of midwives reported that autonomy was only possible when midwives worked alone, as with independent midwifery.

This links with the fact that the medical profession still appear as dominant within maternity services with little impact from midwives working alongside them. This could be seen as the fault of both medics and midwives but if midwives wish to be seen as autonomous they need to not be shy and retiring and exert their dominance within maternity services and exercise their autonomy to lessen the impact of medical interference. This relates to the earlier discussion, within the sub theme of 'culture', on midwives being allowed autonomy in the absence of a professional group.

In relation to midwives, this means that midwives who are valued and respected by their peers and managers have a higher self-esteem and are therefore; more effective in their working practice than those who are undervalued. This was clarified in the literature by Chamberlain (1991:6) who stated that if we do not gain inclusion in management decisions, we will have managers and obstetricians identifying a contracted role that will meet the criteria for an obstetric nurse but not an autonomous midwife.

Yet midwives in this study state autonomy comes from being 'allowed' to act in a certain way by others around them. This was particularly the case within a birth centre or self-employed practice. This again substantiates the query on whether midwives can truly be autonomous professionals if autonomy can only be achieved in the absence of other professional groups when clearly there is multidisciplinary working in all aspects of maternity care.

Alongside the difficulties with professional relationships there was similar issues regarding the supervision of midwives with midwives believing the provision of professional support is the supervisor's most important role in encouraging them to practise autonomously but that this was impeded by the muddling of management and supervision and the interference of managers

rather than the support of supervision as discussed within the literature, 'sometimes this is felt to result from the supervisor confusing her responsibilities and attempting to manage rather than supervise' (Berman, 2000, p273-290).

A positive aspect of having management as supervisory support compared to a clinical midwife was the impact the manager had on organisational change and the remit to offer effective support and act as advocate for the midwife from their hierarchical position. However, there was also conflict with this idea where midwives felt that management interfered in supervision, by closely monitoring individual practice. The benefits would appear to depend on the individual personalities of the managers and the specific relationship with their supervisees.

This also appeared as an issue for the independent midwives who felt they had support from supervisors but had specific ideas about what made a good supervisor for their specific needs. This would agree with the literature which stated that 'these midwives hold quite different expectations of the supervisory function and appeared more pragmatic with regard to the limitations of the supervisor's role.' (O'Connor, 2002). It is possible that this viewpoint may not be the same for midwives practising within an acute trust where midwives do not work so closely with their managers and supervisors; however they did not vocalise this during the interviews.

However, midwives discussed the aspect of self-development with negativity, expressing a view that supervisors should be more supportive by actively encouraging them in development of their skills and organising individual education and development programmes, as well as chasing midwives to attend supervisory meetings. Yet to be autonomous is to be 'self-directed' so these midwives could be seen as not autonomous by nature or in professional practice.

It could therefore be seen from all of these issues that it is not necessarily the NHS system as a whole that does not encourage autonomous practice but particular areas of practice within the NHS and the attitude of colleagues working within it. However, there was a negative attitude from the midwives

towards being employed within the NHS with a view that midwives were caught between how they wanted to practise and how they felt they should practice for the employer. They faced conflict between their professional accountability and fulfilling the requirements of their employers.

Etzioni (1975) demonstrates the use of accountability as a ploy in the power politics of healthcare. He shows that the more powerful an occupational or professional group becomes, then the more others are accountable to them. Although this is a cynical viewpoint there is an element of truth within midwifery practise, during recent years, as midwives become more vocal in maternity care and increase autonomy within their professional practice within roles such as Consultant Midwives posts.

It would appear, therefore, that there is recognition for midwives as autonomous professionals but this needs to increase. Midwives could utilise changes within their working environments to improve this by being more proactive in teaching and encouraging autonomous practice and having more control of policies governing practice by sitting on guideline groups and being involved in writing and updating hospital guidelines with research based evidence.

This was highlighted in this study with a common issue surrounding hospital protocols, where midwives said they did not allow the freedom to practise autonomously but more of a law to abide. Yet, the literature states that professional autonomy is expressed by directing and monitoring practice and is seen as having the ability to make decisions and act on an individual basis without feeling restricted by policies. Independent midwives felt that autonomy was specifically having the freedom to offer individualised care rather than that which is based around guidance for mass numbers of women as is the case within the NHS.

Independent midwives do not have guidelines for everyone to follow as a group therefore each midwife works to their own guidance within individualised care of their women. This may offer more flexibility and scope for their care of women and could be seen as a reason for a woman choosing an independent midwife. However, how each individual midwife decides on

their own guidance and what parameters each midwife has for safety will vary, this poses a problem of inconsistent practice for women opting for this type of care and is an unknown entity for supervision and the NMC.

Midwives within the NHS felt that guidelines were used too much to manage risk and that detracted from them being used as guidance only and allowing individuality and autonomous practice. Perhaps this was due to the care they gave being prescribed by others like obstetricians and therefore they did not feel they were thinking for themselves or making decisions in the care of the women. This then links with those midwives practising within the midwifery led birth centres and independent midwifery who expressed that having autonomy was being able to empower the women to have autonomy in their care which means placing their loyalty to the woman as a priority over their profession.

However, no midwives discussed being actively involved in the process of writing and updating guidelines despite being very negative to their usage. The literature stated that 'within the major units, policy-making was medically controlled, as previous studies have found (Garcia & Garforth 1991, Meah et al. 1996) and in the study by Pollard (2003) in the low-risk units, policies went to the medical staff for 'comments' or for agreement. There was little agreement about the amount or quality of midwifery input into policy-making. Some midwives, who thought they practised autonomously, played a part in drawing up guidelines or said they did not follow policy when they considered it clinically inappropriate. It could be seen then that midwives were restricted in practising autonomously when not involved in the guideline process.

The National Institute for Clinical Excellence (NICE) provides guidelines to clinicians so that all service users can receive evidence-based care (Dimond, 2001); however, these guidelines depend on who is evaluating the available research. Evidence suggests that medical knowledge is always considered superior to midwifery knowledge (McCrea & Crute 1991, Meah et al. 1996). Members of the NICE committees are drawn mainly from the medical profession and NHS management (NICE, 2000 and Thornton, 2001); it appears that NICE guidelines affecting midwifery practice have been developed based on obstetric and paediatric principles, rather than on

midwifery principles (Jowitt, 2001). Midwives of the future need to recognise this and be proactive in changing their position within maternity services as a whole by impacting on clinical guidance and service development.

Although some midwives felt that autonomy within the current system may be unachievable, this pessimistic view may have been a cultural phenomenon, rather than an accurate reflection of reality. Current conditions in the NHS, including the creation of consultant midwife posts, could help to establish midwifery autonomy (Ollerhead, 1999; O'Loughlin, 2001 and Sinclair, 2001); however, this would require a major initiative, both at individual and collective level.

Overall there remains some confusion as to the concept of autonomy and its meaning for midwifery practice. This would appear to vary according to each individual rather than being a standard concept utilised by all midwives once qualified. Certainly in some areas of practice midwives appear to have moved on in their attitude towards autonomous midwifery practice but there still appears to be an obligation to practise according to local conditions and personal inclination. It appears that the midwifery profession still has work to do before being able to truly call the whole profession “autonomous” and when this is reliant on each individual accepting autonomy then this may never happen.

The next and final chapter (10) identifies emerging themes from the previous chapters and based on the study's findings, conclusions are drawn and recommendations proposed.

CHAPTER 10 CONCLUSIONS AND RECOMMENDATIONS

This final chapter gives a brief overview of the whole of this work and presents conclusions drawn from a retrospective survey aimed at evaluating the efficacy of autonomy within the midwifery profession.

The personal journey for me from the commencement of the literature review (BPhil) in 2002 to the culmination of the writing of this thesis for MPhil has been an interesting learning curve albeit long and tough. There have been moments of despair when personal life events, illness and mental fatigue from working full time, caring for my young family and studying part time have delayed the research process and I felt I would never reach the end of this journey. However, through sheer determination and the positive encouragement of my family and supervisors alongside my passion for midwifery and the subject of this thesis, I have reached the final goal in the completion of this study.

I was a novice to research despite many years as a practising midwife; being an advocate of autonomous practice and willing to offer an opinion to any midwifery debate. The biggest hurdle for me has been acknowledging my own bias particularly with the majority of my midwifery experience being within independent midwifery. My own perspective of autonomy within the midwifery profession has altered throughout the process of this study with the accumulation of knowledge on the concept of autonomy and in particular with the results from my own study.

Conclusion

Although within the statutory framework midwives remain autonomous practitioners upon registration (NMC, 2004), this study has shown that the concept of autonomy is an ethereal one; that autonomy is not something that can be given to an individual or attached as a title. Autonomy does not have a particular working definition and is viewed differently by each individual therefore it is a concept that midwives strive to achieve in theory but in practice find impossible.

Of course the influence of historical changes to the provision of maternity care has had a negative impact on autonomous practice for the midwifery profession from the outset (Raynor et al, 2005). The passing of the 1902 Midwives Act could be viewed as detrimental, to midwifery led care and professional autonomy, with its requirement for midwives to work within a medically defined sphere of practice (Clarke 1996). Similarly the Peel Report (1970) promoted hospital birth over home birth and led to the trend we see today for the majority of women to birth in obstetric led environments; therefore rendering midwifery almost invisible to the public, by placing it firmly into the NHS hierarchy. This invisibility is reinforced by the continued regulation of midwives by nurses in the UK, as in the well established Nursing and Midwifery Council (Jowitt, 2000).

Within the current maternity care system the dominance of the medical profession remains evident, reflecting medical principles of care and conceptualising birth as a process that is influenced by science and rationalisation (Edwards, 2004). This medical model is in direct contrast to the midwifery philosophy of care that respects birth as normal and emphasises the importance of individualised holistic care of pregnant women.

Recent Government policies such as the National Service Framework for Maternity Services (2004) and Maternity Matters (2007) promote the normality of birth and midwifery-led care and support midwifery autonomy, in light of these, more opportunities are available for midwives to emerge as leaders, to enhance birthing environments, promote increased choice for women and reassert their autonomous status (Gould, 2005) but this will only happen if midwives use this opportunity and take up the challenge. It will also depend on the other barriers to midwifery autonomy being removed; there is no guarantee that employers are aware of the midwife's distinct role and responsibilities (Anderson 1994) and senior NHS personnel, medical staff and some midwives still do not appreciate that midwives have to assume autonomy.

Although there have been concerted efforts to raise the profile of midwifery over the last decade, this seems to have failed in the broader context (Lewis 2000). Perhaps the inability of midwives to understand and consolidate their

professional autonomy, particularly in terms of interprofessional collaboration and control of their own practice, has contributed to this failure.

It is clear that if midwives are to reassert any form of autonomy it is vital that they become more proactive and less subordinate in the provision of maternity services. They must become actively involved in decision making processes and promote their position within the hierarchical system of health care; it is crucial that midwifery education promotes autonomy and prepares midwives to act at the level required within this hierarchical system and develops midwives who will lead the future of midwifery led care and enhance midwifery autonomy to the benefit of the women using the service.

Although this study, generally found evidences that autonomous practice is a known concept amongst midwives the ability to utilise it on an individual basis varied greatly. Whilst respondents advocated autonomous practice, the findings did not always support this philosophy. Some responses reflected confusion in the interpretation of autonomy and what equates to autonomous practice. The apparent low priority given to acting outside of medical dominance, the restriction of a hierarchical structure and the culture within the working environment; questions the concept of autonomy. This could arguably have implications for the responsibility, accountability and advocacy role of the midwife and again emphasises the view that autonomy is an unachievable concept and can only be an ethereal phenomenon.

Contributions of the study

This study has contributed to the general body of midwifery research by providing:

- Evidence to validate autonomy as a concept within midwifery practice
- Awareness of the barriers for midwives in utilising their autonomy

Limitations of the Evaluation of the Concept of Autonomy

This study has used a small sample to explore one concept of midwifery practice, and as such the researcher recognises that the findings refer to the particular population (mainly London based) of the midwives interviewed. One

therefore is unable to predict that the same results would have emerged had the research been carried out elsewhere in the United Kingdom. However, in light of most of the findings being supported by other research studies, transferability of the findings to other areas of midwifery practice throughout the UK seems feasible.

Recommendations

This study has identified the need to enhance the knowledge base of midwives in respect of the following issues:

- Theoretical underpinning of the concept of autonomy
- Approaches to maternity care eg. Culture, systems and practice area.
- Responsibility, accountability and advocacy role of the midwife and related ethical/legal issues

Short-term recommendations include:

- In-house professional development programmes to address the concept of autonomy
- Active involvement in hospital guideline groups and service development programmes.

Of note is the emphasis, in the most recent Government reports; NSF (2004) and Maternity Matters (2007), on midwifery-led care and choice for women on place of birth and the professional caring for them. In light of this emphasis midwives must ensure research, evidence based practice and critical analysis underpins practice to meet the holistic needs of pregnant women. Ongoing education is vital to improve maternity care and autonomy, thus ensuring no aspect of care is inadvertently omitted through lack of knowledge. The need for expert role models to facilitate the development of all midwives is of paramount importance in their achieving a sound knowledge base and clinical competence which leads to autonomous midwifery practice.

It is further proposed (in the longer term) that:

- Replication of this study in other areas of the UK to determine any significance in workload and place of practice would seem vital in directing the education of midwives in particular to where they will eventually practice.
- A comparative study of work culture including hierarchical systems to determine significance to autonomous practice.

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Authorities and trusts that run the NHS

How is the NHS structured?

The Department of Health, led by the Secretary of State, is the government department responsible for setting the overall direction of the NHS. It sets national standards designed to improve service quality, secures resources and makes investment decisions to ensure that the NHS is able to deliver services.

The Department of Health works with key partners (such as the NHS Modernisation Agency and Strategic Health Authorities) to ensure the quality of services. Authorities and trusts are the different types of organisation that run the NHS at a local level.

Strategic health authorities

Created by the government in 2002 to manage the local NHS on behalf of the Secretary of State for Health, there were originally 28 Strategic Health Authorities (SHAs). On July 1 2006, this number was reduced to 10. Fewer, more strategic organisations will deliver stronger commissioning functions, leading to improved services for patients and better value for money for the taxpayer.

SHAs are responsible for:

- Developing plans for improving health services in their area
- Making sure that services are of a high quality and performing well
- Increasing the capacity of local services so that they can provide more services
- Making sure that national priorities for example, programmes for improving children's services are integrated into local health service plans
- SHA's manage the NHS locally and are a key link between the Department of Health and the NHS. Within each SHA, the NHS is split into various types of trusts that take responsibility for running the NHS at a more local level. SHAs and Government Offices work closely together.

Primary care trusts

Primary care is the care provided by people normally seen when someone first has a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test, or just a trip to a pharmacist to buy cough mixture. NHS walk-in center's and the NHS

Direct phone line service is also part of primary care. All of these services are managed by the local primary care trust (PCT).

PCT's must make sure there are enough services for people within their area and that these services are accessible. They must also make sure that all other health services are provided, including hospitals, dentists, opticians, mental health services, NHS walk-in centers, NHS Direct, patient transport (including accident and emergency), population screening, and pharmacies. PCTs are also responsible for getting health and social care systems working together for the benefit of patients. They will work with Local Authorities and other agencies that provide health and social care locally to make sure that local community's needs are being met.

PCT's are now at the centre of the NHS and control 80% of the NHS budget. As they are local organizations, they are best positioned to understand the needs of their community, so they can make sure that the organizations providing health and social care services are working effectively.

Care trusts

Care trusts work in both health and social care. They are set up when the NHS and local authorities agree to work closely together because it is felt this is the best way to improve local care services.

Care trusts may provide a range of services, including social care, mental health services, or primary care. At present, there is only a small number of care trusts in England.

Acute trusts

Hospitals are managed by acute trusts, which make sure that hospitals provide high-quality healthcare and spend their money efficiently. They also decide on strategy for how the hospital will develop, so that services improve.

Acute trusts employ a large part of the NHS workforce, including nurses, doctors, pharmacists, midwives and health visitors, as well as people doing jobs related to medicine; physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists and psychologists. There are many other non-medical staff members employed by acute trusts, including receptionists, porters, cleaners, specialists in information technology, managers, engineers, caterers and domestic and security staff.

Some acute trusts are regional or national centers for more specialized care; others are attached to universities and help to train health professionals. Acute trusts may sometimes provide services in the community (e.g. through clinics or health centers).

Foundation trusts

These are a new type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population. Foundation trusts have been given more financial and operational freedom than other NHS trusts and have come to represent the government's commitment to de-centralizing control of public services. Foundation trusts remain within the NHS and its performance inspection system. They were first introduced in April 2004, and there are now 67 foundation trusts in England.

Special health authorities

These are health authorities that provide a national rather than local service to the whole of England, either to the public or to the NHS: for example NHS Direct, the National Blood Authority and the Health Development Agency. They are independent, but can be subject to ministerial direction like other NHS bodies.

Standard 11: Maternity Services

1. Introduction

1.1 The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and well-being of children, young people and mothers; and for providing high quality services which meet their needs.

1.2 There are eleven standards, of which this is the last. They cover the following areas:

Standard 1 Promoting Health and Well-being, Identifying Needs and Intervening Early

Standard 2 Supporting Parenting

Standard 3 Child, Young Person and Family-centred Services

Standard 4 Growing Up into Adulthood

Standard 5 Safeguarding and Promoting the Welfare of Children and Young People

Standard 6 Children and Young People who are Ill

Standard 7 Children and Young People in Hospital

Standard 8 Disabled Children and Young People and those with Complex Health Needs

Standard 9 The Mental Health and Psychological Well-being of Children and Young People

Standard 10 Medicines for Children and Young People

Standard 11 Maternity Services

1.3 This standard addresses the requirements of women and their babies during pregnancy, birth and after birth. It includes women's partners and their families; and it addresses and links to pre- and post-conception health promotion and the Child Health Promotion Programme. It should be read in conjunction with Standards 1 – 5.

Maternity Services

Vision

We want to see:

- > Flexible individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women.
- > Women being supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby.
- > Midwifery and obstetric care being based on providing good clinical and psychological outcomes for the woman and baby, while putting equal emphasis on helping new parents prepare for parenthood.

Standard:

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

Markers of Good Practice

1. All women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth.
2. Maternity services are proactive in engaging all women, particularly women from disadvantaged groups and communities, early in their pregnancy and maintaining contact before and after birth.
3. All services facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby.
4. Maternity services are commissioned within a context of managed care networks and include a range of provision for routine and specialist services for women and their families e.g:
 - > Routine ante-natal and post-natal care services;
 - > Services for women with more complex pregnancies who may require multi disciplinary or multi-agency care;
 - > Services for women who request support for coping with domestic violence;
 - > Services for disabled women;
 - > Services for women and their partners who request support to stop smoking;
 - > Services for women and their partners who are substance misusers; and
 - > Services for women and their partners who have mental health problems.
5. Managed maternity and neonatal care networks include effective arrangements for managing the prompt transfer and treatment of women and their babies experiencing problems or complications.
6. All women and their babies receive treatment from health care professionals competent in resuscitation for both mother and infant, newborn examination and in providing breastfeeding support. Services promote breastfeeding, whilst supporting all women whatever their chosen method of feeding.
7. Women who use local maternity services are involved in improving the delivery of these services, and in planning and reviewing all local hospital and community maternity services.

2. Rationale

- 2.1 This standard recognises that, for the majority of women, pregnancy and childbirth are normal life events; it aims to promote women's experience of having choice and control in giving birth to their baby. The standard seeks to improve equity of access to maternity services, which will increase the survival rates and life chances of children from disadvantaged backgrounds. It also aims to ensure that all mothers and babies receive high quality clinical services.
- 2.2 The care and support provided for mothers and babies during pregnancy, childbirth and the post-natal period has a significant effect on children's healthy development and their resilience to problems encountered later in life.
- 2.3 The quality of the service provided for the half a million babies born in England every year, and their mothers, thus has a long term impact on the future health of the nation.
- 2.4 For the majority of women, pregnancy and childbirth are normal life events requiring minimal medical intervention. These women may choose to have midwifery-led care, including a home birth.
- 2.5 For optimum health and well-being all women require easy access to services, choice and control regarding the care they receive and continuity of support during their pregnancy, childbirth and the post-natal period.
- 2.6 Women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies. They are also less likely to breastfeed. In consequence, the outcomes for their own and their babies' health and well-being are worse than for the population as a whole. It is important that services are designed to meet their needs.

- 2.7** The Department of Health national target on improving the health of the population sets out some of the current challenges including the need to focus on reductions in smoking in pregnancy (shared with the Department for Education and Skills), improving nutrition in women of childbearing age, particularly those who are pregnant or breastfeeding; increased breastfeeding initiation and duration rates; effective ante-natal care; and providing high quality midwifery, obstetric and neonatal services in a culturally sensitive way, together with effective family support, focussed on those with high needs. Primary Care Trusts, in partnership with local authorities, will wish to focus on some of these in setting local targets.

Interventions

3. Woman-focused Care

- 3.1** Each pregnancy is different and each woman has different social, physical and emotional needs as well as specific clinical factors that may affect her pregnancy. Good maternity services place the mother and her baby at the centre of care, and plan and provide services to meet their needs.
- 3.2** The majority of women will want to be active participants in planning their care. Most will want to be involved in decisions about which type of care or offers of screening best suits their needs and wishes, and to share responsibility for managing their pregnancy in partnership with their professional care providers.
- 3.3** Promoting the uptake of services involves engaging women and their families in the planning and delivery of services. Inclusiveness can be promoted by ensuring that maternity service planning groups are welcoming, and meeting times and locations take into account womens' access, travel and childcare needs. Maternity Services Liaison Committees (MSLCs) provide a useful vehicle for professional interdisciplinary working with informed user input and may play a useful part in monitoring implementation of this National Service Framework. Payment for expenses (including childcare) should be offered to all invited representatives, plus consideration given to remunerating people for attendance in line with other schemes for service user involvement.

Maternity Services

- 3.4 Partners, fathers, family and peers, may provide significant influence and support for women using the services. *See section 5*

Primary Care Trusts and maternity service providers design, review and improve maternity services through a programme of consultation with women who use the services, their link-workers and advocates, and their families, building on the work of existing local groups including MSLCs. The programme includes individual feedback and review of complaints, surveys, focus groups, audit and review groups, peer/user group input and community groups. *See section 11*

Maternity service providers should ensure that:

- > All pregnant women are offered clear information on the following:
 - a) The full range of choices of types of ante-natal and post-natal care and birth environments;
 - b) The full range of screening tests offered and the consequences of these;
 - c) The availability (from 2005) of Healthy Start (the new Welfare Food Scheme), which provides nutritional support, and advice on diet and health to qualifying pregnant women and young families, and
 - d) The new application process for the current Welfare Food Scheme from 10 October 2004;
- > Women are given enough time between receiving information and making choices to reflect upon the information, consider their options and seek additional information and advice where they wish to;
- > All maternity services have policies and procedures which reflect an individualised, flexible, woman-focused approach to care and support, and
- > In addition to providing support and advice for women, maternity services seek to engage fathers.

4. Care Pathways and Managed Maternity Care Networks

Care Pathways

- 4.1** This National Service Framework is based on the care pathway approach. Care pathways are used to illustrate the woman's progress through the variety of services available. They have emerged in the past decade as an important technique for continuous quality improvement in healthcare and are increasingly seen as a key NHS resource for implementing a National Service Framework. Care pathways formalise evidence-based protocols and guidelines into direct, individual women-focused care. The emphasis is on the woman and her child being at the centre of the process rather than meeting the needs of the service providers. They can be used to describe the routine progression of a woman through the ante-natal period as well as illustrating tracer conditions or situations to show how the standards will be implemented in particular circumstances.
- 4.2** The use of these pathways should result in the same high standard of care being provided for all women. More importantly, if the woman is given a copy of her own care pathway or care plan and it is explained to her, it will enable her to understand exactly how to access additional services should the need arise.

Managed Maternity and Neonatal Care Networks


- 4.3** This National Service Framework will integrate services delivered through the care pathway approach by the introduction of Managed Maternity and Neonatal Care Networks. These are linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services, working together in a co-ordinated manner, to ensure an equitable provision of high quality, clinically effective care. Pregnant women may require care from a variety of sources or professionals, provided through such managed care or social services networks, as well as support from peers and local support groups. Knowing which path to follow, and who is responsible for providing what, will help to reduce clinical variation, eliminate duplication of services, maintain quality of care and adherence to clinical or other guidelines and give professionals agreed control over the care of the delivery process.

4.4 An example of a Managed Ante-natal Maternity network is given in Appendix 1.

NHS Maternity care providers and Primary Care Trusts ensure that care pathways and Managed Maternity and Neonatal Care Networks are in place. This is achieved through a multi-disciplinary and multi-agency approach requiring agreement with all those likely to be involved in providing care, including service managers and all relevant health and social care professionals and service user representatives.

5. Inclusive Services

- 5.1 All women should have easy access to, and confidence in, the full range of high quality maternity services the NHS offers. However, there are women who do not use or who under-use maternity services, most often those in disadvantaged groups or those who do not understand English or are unfamiliar with the NHS. Services may also be provided in places or at times that make them difficult to access or in a manner that may be considered inappropriate to meeting the cultural needs of some women.
- 5.2 Some women are disadvantaged because they have multiple social problems and may find it difficult to access and maintain contact with maternity services. This applies to homeless or travelling women, refugees and asylum seekers, as well as to those who feel they have stigmatising conditions, such as being HIV positive, misusing drugs, alcohol or other substances or those who are experiencing domestic violence. The inter-agency working required to support these women is underdeveloped and needs addressing.
- 5.3 The needs of women in prison and other custodial settings also need to be addressed and their maternity care delivered in accordance with the standards in both this National Service Framework and the NHS Healthcare Standards¹.
- 5.4 Disabled women and those with needs requiring specific services, report that current services are not always responsive to their needs; also, that their own knowledge as to what will suit them best is overlooked.

- 
- 5.5 Maternal and neonatal outcomes are poorer for women from disadvantaged, vulnerable or excluded groups. Teenage parents and their babies from these groups face higher risks of poor outcomes than older parents. They have significantly higher rates of infant mortality, low birth weight, smoking during pregnancy and post-natal depression. However, research suggests that these poor outcomes reflect these young women's low uptake of ante-natal and post-natal support. *See Standard 4*
 - 5.6 Involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long well-being and outcomes of the child (regardless of whether the father is resident or not). Pregnancy and birth are the first major opportunities to engage fathers in the appropriate care and upbringing of their children.
 - 5.7 Young men who become fathers may also come from disadvantaged and vulnerable groups. A positive relationship with the young woman during pregnancy is a key predictor of the father's involvement with his child in the early years. Maternity services can support this relationship through involving and encouraging young fathers but health professionals may know little about teenage fathers and may lack the skills to engage with them.
 - 5.8 Sure Start local programmes and Children's Centres, offering services such as these listed in Box 1, are important components in the national strategy to tackle child poverty and social exclusion. Staff actively engage families in local communities offering a range of services and activities designed to prepare families for birth and parenthood and deliver key public health targets. When midwives are located in Children's Centres, they tend to be more visible and accessible to the community. Consideration should be given to locating some midwives in Children's Centres, managed as a single service providing both community and hospital-based services.
 - 5.9 A report about the experience of Sure Start in involving fathers can be downloaded at www.surestart.gov.uk/_doc/465-6C560D.doc. This includes recommendations to improve this. *See Standards 1 and 3*

Box 1. Sure Start services

Sure Start local programmes and children's centres are currently developing in the 20% most disadvantaged wards and are expected to offer the following services:

- > Visits for families with newborn babies in the area within the first two months following the birth, with information about services and support;
- > Provision of information and guidance on breastfeeding, nutrition, hygiene and safety, to reduce the number of children aged 0 – 3 years admitted to hospital; and
- > Provision of ante-natal advice and support to all pregnant women and their families in the area.

All NHS maternity care providers and Primary Care Trusts:

- > Plan the provision of maternity services:
 - a) Based on an up-to-date assessment of the needs of the local population e.g. identifying specific vulnerable groups or travellers sites (See section 11), and
 - b) Involving service user groups;
- > Improve the access and effectiveness of maternity services for women from disadvantaged and minority groups and communities by systematically taking account of the reasons why women from these groups find it difficult to access and maintain contact with maternity services, and by actively designing services to overcome these barriers to care; and
- > Strengthen services for women from disadvantaged and minority groups and communities by having a staffing profile which, as far as possible, reflects the profile of the local population.

- > With asylum seeker accommodation or a women's prison in their locality, have in place arrangements to link health care services for expectant women and mothers with newborns to local maternity services and ensure that these standards are applied in every setting.
- > Ensure that local maternity services are inclusive for women with learning and physical disabilities taking into account their communication, equipment and support needs.
- > Provide maternity services for teenage parents in line with *Teenage Parents: Who Cares? – a guide to commissioning and delivering maternity services for young parents*². Maternity services staff have the knowledge and skills to engage with teenage mothers and fathers.
- > Make provision for translation, interpreting and advocacy services based on an assessment of the needs of the local population. Provision includes a mixed economy of interpreting and advocacy services – for home visiting, out-of-hours services, ante-natal classes. (See *Committee for Racial Equality, Maternity services code of practice*³, particularly in relation to providing translation and interpreting services.)
- > All NHS maternity care providers, Primary Care Trusts and Local Authorities monitor the take-up of services, quality of service user engagement and outcomes for women and their babies from disadvantaged and minority groups and communities; and take action to provide high quality midwifery, obstetric and neonatal services in a culturally sensitive way as part of the broader strategy of improving the health of the population (a Department of Health national target).
- > Develop a directory of local and national agencies who can provide expert advice and support for professionals working with women from disadvantaged and minority groups and communities.

Maternity Services

- > Improve take-up of community maternity services and support for all pregnant women and new parents by:
 - a) Ensuring general practitioners, primary care staff and receptionists immediately refer pregnant women to the local maternity services and stress the importance of this care to women they see for reasons other than their pregnancy;
 - b) Extending accessible midwifery services, including some co-location, in Children's Centres where disadvantaged women regularly attend;
 - c) Extending the Sure Start principles across other services i.e. working with parents and children, starting early, being responsive to women's needs, flexible at the point of delivery, providing services for everyone, ensuring services are community-driven, professionally co-ordinated across agencies and outcome focused, and
 - d) Engaging fathers and partners through services as part of preparation for parenthood.
- > Have inter-agency arrangements, including protocols for information sharing and a lead professional, to ensure that women from disadvantaged groups have:
 - a) Adequate support from other agencies which forms part of the package of care needed to promote the health and well-being of the mother and her baby;
 - b) The benefit of health promotion initiatives at every opportunity. (See *Delivering the Best – midwives contribution to the NHS Plan*); and
 - c) The benefit of other agencies (e.g. housing) referring women, with consent, quickly and easily to local maternity services.

All NHS maternity care providers and Primary Care Trusts develop 'community-based continuity of care' schemes for women from disadvantaged and minority groups and communities.

6. Pre-Conception Care

- 6.1 Parents who are fit and healthy at the start of pregnancy generally have healthier babies. About half of pregnancies in the United Kingdom are unplanned and some women may delay seeking advice once they know they are pregnant, for a variety of reasons.
- 6.2 Prospective parents do not currently have easy access to information, such as the importance of folic acid supplementation prior to conception and ensuring rubella immunity, as rubella infection in the first eight to ten weeks of pregnancy results in fetal damage in up to 90% of infants.
- 6.3 Some women and prospective parents need specialist pre-conception advice, information and support, including:
 - > Women who have conditions treated with medicines that may harm the unborn baby need advice about changes in their medications prior to pregnancy; such conditions include epilepsy, schizophrenia, hypertension and bi-polar affective disorders;
 - > Women with a condition such as heart disease, a history of embolism, epilepsy or diabetes will need information and advice to ensure that their treatment is optimised, about managing their health before conception and during pregnancy, and
 - > Prospective or existing parents with a family history of a genetic disorder, and those who are concerned about familial disease or disabilities.
- 6.4 There are significant risks to the health, and life, of a baby if the mother smokes. These include the risk of miscarriage, premature birth and stillbirth, of placental abnormalities, low birthweight and, after birth, sudden infant deaths. It is estimated that about one third of all perinatal deaths in the UK are caused by smoking. There is also a significant risk to fetal development with women misusing drugs or alcohol (see also paragraph 7.10).

Maternity Services

All NHS maternity care providers, Primary Care Trusts and Local Authorities ensure that:

- > Local multi-agency health promotion arrangements include health promotion for pregnancy;
- > Campaigns and materials are targeted towards women in groups and communities who under-use maternity services or who are at greater risk of poor outcomes (*see Box 2*);

Specific pre-conception services are available within the maternity care network and publicised for all women and their partners who require specialist advice before becoming pregnant, because of pre-existing medical or familial conditions;

The maternity care network works closely with primary health care providers, family planning and sexual health services to identify women with pre-existing medical or familial conditions who may become pregnant and ensure they have pre-pregnancy access to specialist advice should they plan to become pregnant, or appropriate contraception if they do not, and

All pregnant women and their partners who smoke receive clear information about the risks of smoking and the support available to them to stop e.g. the NHS Stop Smoking Service as part of the broader strategy of improving the health of the population (a Department of Health national target).

Box 2. Pre-conception information for parents

Local health promotion arrangements need to include the provision of the following information for parents:

- > What becoming a parent might be like and the impact on wider family/adult relationships.
- > The importance of:
 - a) pre-conceptual folic acid;
 - b) minimising intake of alcohol;
 - c) not using recreational drugs;
 - d) not smoking during pregnancy and having a smoke-free environment;
 - e) pre-pregnancy rubella immunisation, and
 - f) seeing a healthcare professional as early in pregnancy as possible.

See also Department of Health's *The Pregnancy Book* and Dr Foster local maternity guides - *You're Pregnant*. (www.drfooster.com) *See Standard 3*



7. Pre-Birth Care

- 7.1 Approachable and supportive ante-natal services in convenient and accessible settings encourage and enable women to engage with maternity services early in their pregnancy and maintain contact throughout the pregnancy, the birth and the early post-birth period. It is recommended in the National Institute for Clinical Excellence (NICE) Ante-natal Care Guidelines⁵ that women have access to maternity services at 8 – 10 weeks of pregnancy to give them time to plan their pregnancy effectively and consider early screening options.
- 7.2 Some women, particularly those from more vulnerable and disadvantaged groups, may require more support and access to social or other services, e.g. housing, advice on benefits and, where appropriate, child maintenance and relationship support.
- 7.3 Delivering effective ante-natal care is dependent upon effective and sensitive provision of non-directive information and support. Feedback from parents⁶ suggests that they want more information than is currently provided for them, particularly for first-time parents, fathers, young parents, those who are in disadvantaged or minority ethnic groups.
- 7.4 As pregnancy progresses, women's information requirements change. Good ante-natal care for all women and their partners will also include access to parenting education, and preparation for birth as classes or through other means to enable them to make informed choices about the type of birth they would prefer.
- 7.5 Women need general and individual information about taking medicines during their pregnancy. *See Standard 1*

All NHS maternity care providers and Primary Care Trusts ensure that:

- > The option for all women to access a midwife as the first point of contact is widely publicised;
- > Contact details for midwives are easily accessible to all women in the local population, and
- > Each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services;

All NHS maternity care providers and Primary Care Trusts ensure that midwives, obstetricians and general practitioners are competent to assist women in considering their options for ante-natal, birth and post-birth care, and the clinical risks and benefits involved. In addition to local information to assist such choices, women are informed of relevant local and national voluntary agencies and websites.

All women are offered the support of a named midwife throughout pregnancy. All women are able to contact a midwife day or night at any stage in pregnancy if they have concerns;

Every woman develops and is encouraged to regularly review, her individual care plan in partnership with a health care professional. The plan is based on an assessment of each woman's clinical and other needs and she and her health care professional are able to discuss changing it at any point in her pregnancy;

Women have access to information and advice about taking any medicines during their pregnancy, and

Every pregnant woman attending an Accident and Emergency department for problems other than obvious minor injuries is seen by a midwife or obstetrician. Where this is not possible, a midwife or obstetrician is consulted by telephone.

Maternity Services

- 7.6** Ante-natal care should maximise positive clinical outcomes as well as providing support and reassurance.
- 7.7** Women require information in a medium or language which suits their needs. In early pregnancy, they need to decide which, if any, screening tests they wish to have. It is particularly important that women give properly informed consent to have any tests before these procedures take place. See the National Screening Committee at www.nsc.nhs.uk and www.nelh.nhs.uk/screening

All NHS maternity care providers and Primary Care Trusts ensure that:

- > A comprehensive high quality ante-natal screening and diagnostic service, based on the current recommendations of the National Screening Committee and designed to detect maternal or fetal problems at an early stage, is offered to all women;
- > Ante-natal tests and screening are offered to women as options (with the purpose and consequence of each test explained), rather than as a routine part of the process of being pregnant;
- > Staff working with women in the pre-conception and ante-natal period are competent in recognising, advising and referring women who would benefit from more specialist services;
- > All relevant clinical guidelines from the National Institute for Clinical Excellence are followed, for example the Guidelines for Routine Ante-natal Care⁵, and
- > Where women request or decline services or treatment, their decision is respected.

Pre-Birth Mental Health

- 7.8 The transition to parenthood is associated with psychological change and emotional upheaval. All those concerned with the care of women and their families at this stage in their lives need to be familiar with the normal emotional and psychological changes that take place during pregnancy and in the post-natal period. They also need to be familiar with the signs and symptoms of common crises, the likely causes of these crises, and the states of distress that arise in relation to obstetric and other events.
- 7.9 Mental health problems and mild non-psychotic psychiatric illnesses are common both in pregnancy and following birth. The incidence of serious mental illness is reduced during pregnancy but increased following delivery. A significant minority of women will have a psychiatric disorder during pregnancy which may continue following delivery and compromise their adjustment to motherhood.
- 7.10 Women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multi-disciplinary and multi-agency team.
- 7.11 Professionals should also consider the effect these problems may have on the woman's ability to meet the needs of her baby. Where there are concerns about the unborn baby's welfare, or the welfare of the baby after birth, a referral should be made to social services for an assessment of the mother and baby's needs, and for social care services to be provided as required.
- See Standard 2*

Maternity Services

All pregnant women have easy access to information about the normal emotional and psychological changes during pregnancy and following birth, advice on promoting well-being and simple coping strategies. It should also include information on mental health problems and how to access appropriate help.

All NHS maternity care providers have in place policies and protocols for identifying and supporting women who are at high risk of developing a serious postpartum mental illness, which will help to deliver the Department of Health national target on improving the health of the population which includes reducing mortality from suicide. These include ensuring that all pregnant women are:

- > Asked about any previous history of psychiatric disorder and/or family history of serious mental illness early in their pregnancy; and
- > Provided with information on pregnancy and mental health which helps them to disclose and discuss mental health issues.

Midwives and obstetricians are competent to elicit the relevant information sensitively and identify serious intercurrent conditions or a potentially serious past psychiatric history.

All NHS maternity care providers and Mental Health trusts have in place joint-working arrangements for maternity and mental health services, including arrangements for direct access by midwives, general practitioners and obstetricians to a perinatal psychiatrist. (See women's mental health guidance: *Women's Mental Health: Into the Mainstream?*).

All women who have a significant problem drug and/or alcohol use should receive their care from a multi-agency team which will include a specialist midwife and/or obstetrician in this area.

Maternity and social services have joint-working arrangements place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother's needs and circumstances.

Domestic Violence

- 7.12** Almost a third of domestic violence begins with pregnancy. Feedback from pregnant women already in abusive relationships is that existing abuse often intensifies during pregnancy. The effect of violence on the unborn baby can lead to miscarriage, stillbirth, intra-uterine growth retardation and premature birth as well as to long lasting physical disability. For the mother, violence can cause life-threatening complications and sometimes result in her death.
- 7.13** Furthermore, violence has a major impact on the mental and physical health of the wider family, particularly as violent partners are often violent towards their children as well. *See section 7.11*
- 7.14** The recommendations of the two most recent *Confidential Enquiries into Maternal Deaths*^{8,9} (CEMD) reports underline the importance of providing an enabling environment for women to disclose violence, if they so wish, to the health care professional caring for them during pregnancy. This will enable the women to be offered access to the help and support they want.
See Standard 5



Maternity Services

All NHS maternity care providers and Primary Care Trusts ensure that:

- > All pregnant women are offered a supportive environment and the opportunity to disclose domestic violence; and local support services and networks are developed and midwives and other health professionals involved are trained to respond appropriately.
- > Maternity service staff are aware of the importance of domestic violence in their practice and are competent in recognising the symptoms and presentations. They are able to make a sensitive enquiry if concerned and can provide basic information about, or referral to, local services as required.
- > As part of the local inter-agency domestic violence strategy, joint working arrangements are in place between maternity services and local agencies with responsibility for dealing with domestic violence; information about these services is made available to all pregnant women whether they are affected by violence or not and, if they are, irrespective of whether they choose to disclose it.

Maternity and social services have joint working arrangements in place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother's needs and circumstances.

See *Domestic Violence: a resource manual for Healthcare Professionals*¹⁰ and www.northbristol.nhs.uk/midwives/domesticviolence

Problems in Early Pregnancy

- 7.15** A significant number of women develop problems in early pregnancy which require quick and sensitive assessment. Up to 20% of pregnancies miscarry and one in a hundred pregnancies will occur outside the womb (ectopic pregnancy). The latter can be life-threatening unless diagnosed early and dealt with quickly.
- 7.16** Successive Confidential Enquiries into Maternal Deaths Reports have highlighted delays in the diagnosis of ectopic pregnancy, sometimes with fatal results. It is therefore crucial that all women with worrying symptoms in early pregnancy can be rapidly assessed and treated as required.
- 7.17** Many hospitals have established Early Pregnancy Units (EPUs) to allow such rapid assessment. However, a clear need exists to enable equitable access to rapid and skilled care for those women currently unable to access these services.



- 7.18 For women and their families who experience miscarriage, ectopic pregnancies or other early pregnancy loss, this means the loss of a baby. The Miscarriage Association (www.miscarriageassociation.org.uk) provides support for parents and others affected by miscarriage or ectopic pregnancy www.miscarriageassociation.org.uk and Ante-natal Results and Choices (ARC) www.arc.org.uk provides support and information to parents faced with the choice of whether to continue with a pregnancy where the baby has a congenital anomaly. Both agencies provide training for staff.

Primary Care Trusts and maternity care providers ensure that:

- > Every woman who is experiencing problems in early pregnancy has access to an Early Pregnancy Unit (EPU);
- > Every pregnant woman whose unborn baby is found to have a possible problem has access to high quality, appropriate services in an environment sensitive to her, and her partner's needs;
- > As a minimum, EPUs need to have access to high quality ultrasound equipment and suitable expertise, other methods of assessment and therapeutic expertise, and provide a suitable environment for worried or distressed mothers and their partners, and
- > Diagnostic guidelines are circulated to all health professionals likely to be consulted by a woman who may have an ectopic pregnancy.

There is a clear and consistent local policy about the sensitive disposal of fetal tissues after early pregnancy loss.

Women with three or more miscarriages are offered a referral to a specialist recurrent miscarriage clinic.

8. Birth

Promoting Normality and Choice, and Improving Women's Experiences of Care

- 8.1 Every woman is able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she or her baby may have.
- 8.2 Women's reactions to their birth experiences can influence their emotional well-being, their relationship with their baby and their future parenting relationships.

Box 3. What women want

A number of studies have shown that the main things that women want when giving birth are:

- > To have confidence in staff providing care during the birthing process;
- > To have one-to-one care from a named midwife throughout labour and birth, preferably whom they have got to know and trust throughout pregnancy;
- > To receive personalised care, be treated with kindness, support and respect;
- > A pleasant and safe birth environment;
- > To receive adequate information and explanations about their choices for childbirth, including pain relief and hospital practices, and
- > Access to medical help if complications arise.

- 8.3 Several large studies on home birth have concluded that it appears safe for women who have been appropriately assessed. Home births should be offered within a risk management framework and with adequate local infrastructure and support.

NHS Maternity care providers and Primary Care Trusts ensure that:

- > The range of ante-natal, birth and post-birth care services available locally constitutes real choice for women (including home births) (See also section 11);
- > Staff actively promote midwife-led care to all women who have been appropriately assessed;
- > Local options for midwife-led care will include midwife-led units in the community or on a hospital site, and births at home for women who have been appropriately assessed. Care should be provided within a framework that enables easy and early transfer of women and babies who unexpectedly require specialist care. As with other options, the outcomes of these types of care should be regularly audited;
- > The capacity of the midwife-led and home birth services are developed to meet the needs of the local population;
- > Staffing levels and competencies on delivery suites comply with *Clinical Negligence Scheme for Trusts*¹¹ standards;
- > Women have a choices of methods of pain relief during labour, including non-pharmacological options;
- > All staff have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools, and in their position of choice;
- > Midwives and doctors who care for women with epidurals have regular updated training from anaesthetic staff;
- > Clinical interventions, including elective caesarean section, are only performed if there is clinical evidence of expected benefits of these to the mother and/or baby;
- > A consultant is involved in the decision to undertake any caesarian section, and
- > Maternity services develop the capacity for every woman to have a designated midwife to provide care for them when in established labour for 100% of the time.

The Birth Environment

8.4 Feedback from women is that wherever they choose to give birth the environment should:

- > Be quiet, relaxed with comfortable "home-like" surroundings where they can progress through labour with the support of their birth partners;
- > Facilitate companionship, empathy and help as well as skilled professional care, and
- > Enable women to do what feels right for them during labour and delivery with health professionals supporting their wishes wherever possible.

All NHS maternity care providers and Primary Care Trusts ensure that birth environments in all settings:

- > Promote the normality of childbirth i.e. they replicate a home-like ambience;
- > Can have furniture easily re-arranged to allow for mobility and different birth positions;
- > Wherever possible, allow access to a birthing pool with staff competent in facilitating water births; and
- > Are welcoming to fathers and other birthing partners.

(See Health Building Note 21 *Facilities for Maternity Care* NHS Estates website).

All NHS maternity care providers ensure that maternity units and services are:

- > Accessible to disabled women in line with the *Disability Discrimination Act 1995*¹² (including home births where appropriate);
- > Innovative and flexible in meeting the needs of women with communication and other disabilities, and
- > Informed by best practice from settings and regions across the country in caring for disabled women.

Should Complications Arise

- 8.5** Complications, which can arise for both mother and baby, need to be treated quickly and in accordance with best clinical practice. Immediate, safe transfer should be available for any mother or baby who needs to transfer to consultant care in labour or after delivery. These arrangements are an integral part of the local care network.

All NHS maternity care providers and Primary Care Trusts ensure that:

- > All professionals providing maternity care undertake regular, specific, ongoing on-site training on the early identification and referral of women with obstetric or other medical complications. This includes cardiac arrest and haemorrhage procedures for the management of obstetric emergencies on site in the maternity unit;
- > Formal local multi-disciplinary arrangements are in place for emergency situations, including transfer-in labour for all out of hospital or intra-hospital settings;
- > Community-based facilities are fully equipped and staff have the skills for initial management and referral of obstetric and neonatal emergencies;
- > In all out-of-hospital labours/births, the midwife is responsible for transfer and continues to care for the woman on transfer where possible;
- > For all transfers to hospital, midwives refer directly to the most senior obstetrician on call, and
- > Consultant-led services have adequate facilities, expertise, capacity and back-up for timely and comprehensive obstetric emergency care, including transfer to intensive care.



9. Post-Birth Care for Mothers

- 9.1 Women need to be provided with a post-natal care service that identifies and responds in a structured and systematic way, to their individual physical, psychological, emotional and social needs, and which is based on the best available evidence. This should be achieved through a multi-disciplinary team-based approach, with a co-ordinating health professional who has the appropriate clinical skills to ensure that the mother receives the post-natal care she needs, and that the parents are able to care for their child. Within this framework, midwives and health visitors work closely together. When the mother and her baby's post-natal needs have been met, responsibility for her care and support can be transferred to the health visitor.

Immediate Post-Birth Care

- 9.2 All Surveys repeatedly show more negative comments from service users in relation to hospital post-natal services than about any other aspect of maternity care. Many of the complaints focus on women receiving conflicting advice on infant feeding, the availability and quality of hospital food and poor standards of hygiene.
- 9.3 This is an area where maternity support workers could have an important role. They would receive appropriate training and would work under midwife or health visitor supervision in hospital (or community post-natal care teams – see 9.6 below), providing basic care and support for women and their babies. This could include infant feeding advice and general information about the hospital environment including catering, washing and visiting arrangements. Proposals to introduce maternity care support workers as part of the maternity team have been endorsed by women using maternity services.

Maternity Services

In hospital settings, each woman receives an initial assessment of her needs and agrees a care plan with the midwife which takes into account the type of birth, expected length of stay in hospital and the timing of her transfer home.

All NHS maternity care providers implement and evaluate innovative models of support services e.g. appropriately trained maternity support workers integrated into both the hospital and community post-natal care teams.

All women leaving hospital or in the community, receive support from a community-based co-ordinating health professional.

Box 4. Information for parents

Local health promotion strategies need to include the following information for both mothers and fathers:

- > Healthy lifestyles including skills and knowledge of the purchase and preparation of food to form a balanced diet, active lifestyle and the importance of maintaining a healthy weight;
- > The benefits of breast-milk and how to breastfeed and, where this is not possible, how to bottle feed safely; healthy weaning at six months;
- > Reducing the risks of sudden infant death; accident prevention, reducing non-intentional injury and first aid and basic life-saving skills to use with babies and children;
- > What to expect at different ages including, emotional development, growth and child development;
- > How to nurture babies and children, and
- > Services to support parents and children through disrupted relationships and bereavement.

See also Department of Health/Dr Foster local maternity guides and *Birth to Five*¹³, and Standard 3.

Ongoing Community Care

- 9.4** The current duration of community post-natal care, with routine midwife discharge at 10 to 14 days and routine discharge from maternity care at six to eight weeks, now appears too short for a full assessment of health needs, given the long term nature of many post-delivery health problems. A survey by the National Childbirth Trust found that women reported not having enough help and information between 11 to 30 days after birth, compared with the first ten days. Accordingly, midwifery-led services should provide for the mother and her baby for at least a month after birth or discharge from hospital, and up to three months or longer depending on individual need.
- 9.5** Studies have shown that a new mother's health problems are often not identified or reported prior to post-natal discharge. Many of these health problems can persist in the long term leading to ongoing pain, disability and depression. Their early identification and management is important for the continuing health of the mother and her family.
- 9.6** Additional necessary support can be provided through a maternity support worker service, with midwife or health visitor supervision as part of a community post-natal care team (*see section 9.3*). Other support may be provided by peer support initiatives and Sure Start early years services. There is evidence that peer support programmes can have a positive impact in improving breastfeeding rates.
- 9.7** Over a quarter of births conceived to young women aged 17 and 18 are second pregnancies. Although some of these will be planned, many are not. Good quality contraceptive advice and treatment are essential to ensure that young women are able to prevent subsequent pregnancies if they wish to.

Maternity Services

All women receive a structured needs assessment in the post-natal period, using a recognised assessment tool which enables health professionals to systematically identify, record and promote the health and well-being of the mother and her baby. As part of this individual care model, the mother, together with professionals, plans for her ongoing care and support needs.

Post-natal care includes provision of information to both mothers and fathers on infant care, parenting skills and accessing local community support groups.

Arrangements are in place for support in the community for teenage parents, with relevant agencies such as Connexions and Sure Start Plus; including the provision of contraceptive advice and treatment.

All NHS maternity care providers, Primary Care Trusts and Local Authorities support voluntary sector agencies in providing local services for parents of babies and young children.

Local policies ensure that women are discharged from the maternity service according to their individual needs and those of their babies.

Post-Natal Mental Health Needs

9.8 Maternal post-natal depression, with a prevalence of 10 – 15%, has been shown in several studies to have adverse effects on the baby, including insecure attachment, cognitive development deficits and increased likelihood of psychiatric illness, and some of these can persist in the longer term. The identification and management of psychological health therefore is crucial for the child as well as the mother.

- 9.9 Despite enquiries about previous ill health during the ante-natal period, the majority of women who develop serious mental health problems following birth will probably not have been identified previously as being at risk. The most serious illnesses tend to develop by six to eight weeks after birth. Seriously ill women, whose needs cannot be met by primary care, will require the assistance of Specialist Perinatal Psychiatric Services and sometimes admission to a Specialist Mother and Baby Psychiatric Unit. *See Standard 2*

All professionals involved in the care of women immediately following childbirth need to be able to distinguish normal emotional and psychological changes from significant mental health problems, and to refer women for support according to their needs.

All professionals directly involved in the care of each woman who has been identified as at risk of a recurrence of a severe mental illness following birth, including the woman and her family (as appropriate), are familiar with her individual 'relapse signature' (the early signs of the developing illness).

Each woman who has been identified as at risk of a recurrence of a severe mental illness has a written plan of agreed multi-disciplinary interventions and action to be taken.

Strategic Health Authorities and all NHS Trusts plan for the provision across Strategic Health Authorities boundaries, of sufficient capacity for specialist in-patient psychiatric mother and baby treatment so that all women who require it can be admitted with their baby (unless there is a specific contra-indication) to a Specialist Mother and Baby Psychiatric Unit.

10. Post-Birth Care for Babies**Immediately Following Birth**

- 10.1** Babies need early and ongoing contact with their mothers and fathers. They may also need care and treatment from health care professionals skilled in appropriate resuscitation methods, examination of the new born to identify problems and in assisting with the chosen method of infant feeding.

See Standard 1

All staff who attend a woman in childbirth or who deal with newborn babies, irrespective of the place of delivery, have been trained in neonatal life support and have up-to-date skills in the techniques of neonatal resuscitation and the thermal care of infants at resuscitation.

All appropriate NHS Trusts have in place specialist transport services for transferring babies between hospitals as part of their locally agreed managed maternity and neonatal care network.

Routine Examination of Newborn Babies

- 10.2** All newborn infants should receive a physical examination to detect treatable, but pre-clinical, congenital problems in the early neonatal period. However the current practice of examinations being undertaken by junior doctors has led to significant delays in mothers and babies being discharged from hospital. It is therefore proposed that a range of professionals can undertake the first examination, as long as they are trained and skilled in this procedure.

See Standards 1 and 8

All newborn infants have a clinical examination to detect pre-clinical abnormalities within the first week of life for full term babies, or prior to discharge home from neonatal care.

Professionals are skilled in sharing concerns and choices with parents as part of the emerging diagnosis (see *Right from the Start* template¹⁴).

Both parents are encouraged to be present at the first examination.

Professional staff examining newborn babies have up-to-date training in neonatal examination techniques. Prompt referral for further medical investigation or treatment is provided through agreed clinical care pathways.

Infant Feeding

10.3 There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer term. Breastfeeding has an important contribution to make towards meeting the national target to reduce infant mortality and health inequalities. Women from lower socio-economic groups have lower breastfeeding rates than those from higher socio-economic groups, and teenage mothers are half as likely to breastfeed as older women.

10.4 The infant feeding survey showed that 90% of mothers who gave up breastfeeding within six weeks of birth would like to have breastfed for longer. Some of the reasons for stopping breastfeeding were found to include a lack of ante-natal information concerning breastfeeding, delays in the first feed and a lack of post-natal help with breastfeeding problems.

- 10.5** Mothers who are taking medicines need particular advice about breastfeeding. Current information sources available to health professionals may lead to women being advised, unnecessarily, not to breastfeed, because of the medicines which they are taking.

Information on breastfeeding is timely, consistent and reflects best practice standards; this will help to deliver the Department of Health PSA target on improving the health of the population.

Support for breastfeeding is a routine part of ante-natal care, birth and post-natal care, with particular support for mothers who have had a multiple birth or have a premature or sick baby.

NHS Trusts have, as a minimum standard for breastfeeding support, the best practice guide *Good Practice and Innovation in Breastfeeding*¹⁵.

Arrangements are in place for women to easily access breast-feeding support services e.g. community-based networks offering mother-to-mother support and trained breastfeeding counsellors working within, or closely with, the health care system.

Women who are taking medicines receive specialist advice, based on best available evidence, in relation to breastfeeding.

Stillbirths and Early Neonatal Deaths

- 10.6** Despite improvements in all aspects of care for pregnant women, some still lose babies through stillbirths and death in the first week of life (in 2003 the figure was 8.5 stillbirths and deaths under one week, per thousand live births and stillbirths in England).

10.7 Women, their partners and sibling children who have suffered a bereavement arising from a pregnancy, whether a miscarriage, termination, stillbirth, neonatal and infant death or the death of the mother herself, will need supportive information and choices which are:

- > Responsive to their individual needs and those of the family;
- > Easily accessible for as long as required;
- > Consistent in content across all sectors of the health service;
- > Appropriate and based on the relevant guidelines, and
- > Respectful of culture and diversity.

10.8 The Child Bereavement Trust provides a range of resources for professionals and bereaved families. A particular concern is support to siblings when a child dies www.childbereavement.org.uk; The Compassionate Friends is a peer support group for those bereaved by the death of a child or children www.tcf.org.uk and CRUSE provides training in bereavement for professionals, written information for the bereaved including for children of various ages www.crusebereavementcare.org.uk. See also Guidelines issued by the Stillbirth and Neonatal Death Society. *See Standard 8*

All NHS maternity care providers ensure that all health services have comprehensive, culturally sensitive, multi-disciplinary policies, services and facilities for the management and support of families who have experienced a maternal or neonatal death or stillbirth.

Skilled staff are available to support parents following maternal or neonatal death, stillbirth or miscarriage.

Information is available in different languages, with particular cultural beliefs or sensitivities appropriately reflected.

11. Quality of Care

See Standards 3 and 7

- 11.1** Clinical governance is the framework through which organisations providing maternity services can manage their accountability for maintaining high standards and continuously improving the quality of their services.

Women who are assessed as needing clinical interventions during their pregnancy, through birth and in post-birth care receive high quality, evidence-based care in line with the Department of Health national target on improving the health of the population.

Maternity services comply with the National Institute for Clinical Excellence (NICE) guidelines for the provision of high quality clinical care including the provision of ante-natal, intrapartum and postpartum care and caesarean sections, as and when they are available and updated.

Routine Data Collection and Analysis

- 11.2** The Government recognises that data from NHS maternity care providers is important as it provides a measure, not only of the health of pregnant women, but also of their babies. Data on the mother's health plays an important part in the child's health record, so maternal and child health should be linked. Such information, on processes and outcomes, also informs continuous improvement in local maternity services to best address local needs.

Primary Care Trusts and NHS Trusts ensure that maternity data is collected and made available in accordance with recognised best practice, and agreed national datasets once published.

Learning from Adverse Events and Research

11.3 High quality care requires an evidence-based culture which relies on well-designed clinical research.

All maternity care providers and Primary Care Trusts ensure that:

- > Multidisciplinary review of critical incidents are a routine learning exercise for staff;
- > All staff participate in the relevant Confidential Enquiries into maternal, perinatal or infant deaths, and
- > Maternity units actively engage in well-designed, ethical, clinical research that aim to improve care for pregnant and recently pregnant women and their babies.



Maternity Services

12. Training and Development

12.1 The delivery of maternity services to this standard is dependent on all maternity services staff being trained and supported to work within the full range of their competences. This may include the development of new roles, for example:

- > Appropriately trained maternity support workers, integrated into both the hospital and community post-natal care teams;
- > New advocate and link worker roles; and
- > New Consultant Midwife roles.

12.2 Although not all the core competencies set out under Standard 3 are applicable to staff providing maternity services, some are relevant, such as those regarding equality and diversity, communicating with parents (mothers and fathers) and safeguarding children.

12.3 Competencies or national occupational standards relating to maternity and neonatal services are being developed by *Skills for Health* as part of the Children's National Workforce Competence Framework for Children's Services¹⁶.

Maternity services staff have the core competencies set out under Standard 3 which are relevant to maternity services.

Clinical staff have appropriate, multi-disciplinary training to ensure that they work in partnership, including inter-agency, with a shared philosophy of care.

In addition, specific training is needed so that advocates and translators understand the provision of maternity care and social services so that they can effectively help to guide women around the system.

All maternity care providers and Primary Care Trusts ensure the implementation of the anticipated national occupational standards relating to maternity and neonatal services.

13. Planning and Commissioning Maternity Services

- 13.1 All NHS Trusts, together with their neighbouring NHS Trusts and social service departments and, if necessary Local Strategic Health Authorities, should plan and commission maternity services as part of a locally agreed and managed network of maternity and neonatal care appropriate and accessible for all women. *See Standard 3*

Any reconfiguration of maternity services provides services which:

- > Are more woman-focussed and family-centred;
- > Expand community based provision; and
- > Enhance the network of care for women requiring specialist, particularly tertiary care.

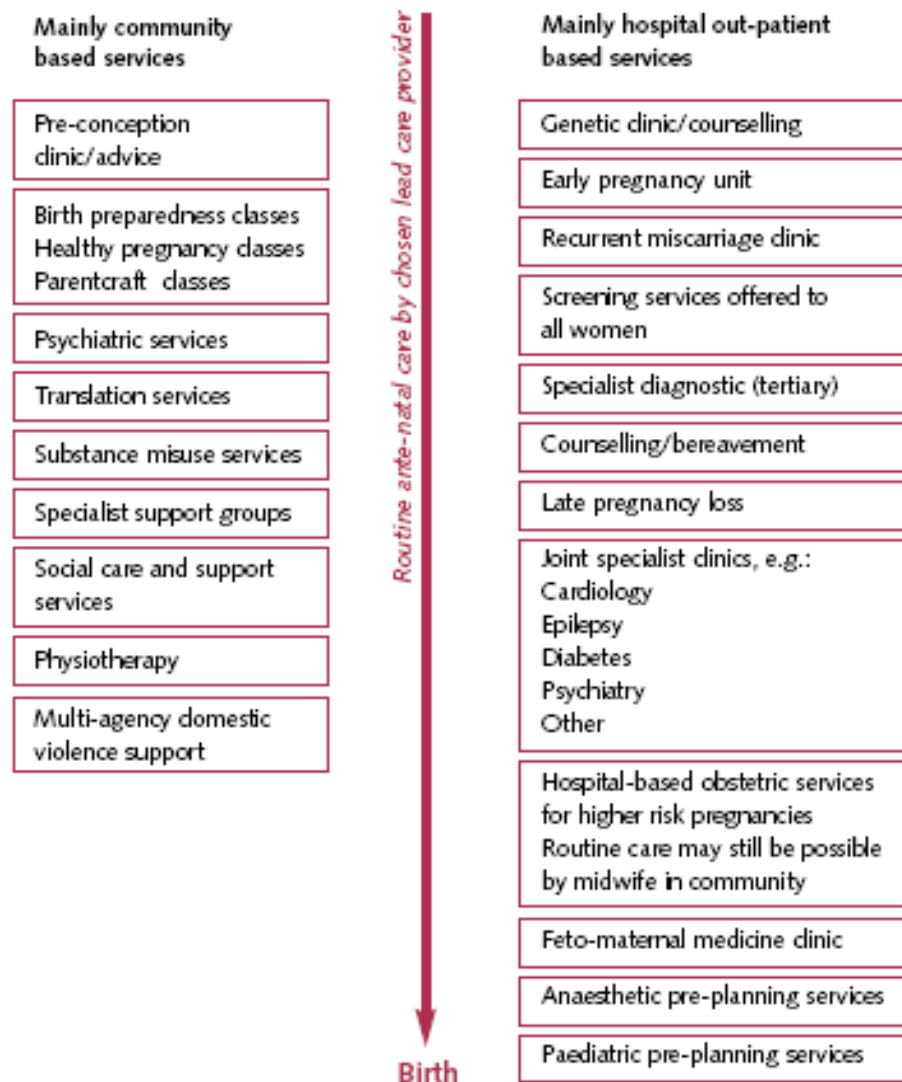
The assessment and planning of services takes into account the availability of IT equipment and networks, local transport services, access to facilities for wheelchairs or baby buggies and for women with physical, sensory or learning disabilities; and access for women from disadvantaged or minority groups.

Strategic Health Authorities, Primary Care Trusts and NHS Trusts implement a service user involvement programme for maternity services and ensure that the local population has representation on a Maternity Services Liaison Committee (MSLC), within a clinical network.

Primary Care Trusts and NHS Trusts have local interagency information sharing and working arrangements between all agencies providing care to women and their families. The arrangements reflect recent guidance on information.

Appendix 1:

An example of a possible Managed Care Network for Ante-natal Care





**In-patient
services**

In-patient or day
care gynaecology/
termination of
pregnancy

Referrals to and between services are managed through agreed and understood multidisciplinary protocols. The woman's lead carer refers direct and acts as gateway and keeps in regular touch with the woman and the services she receives

In-patient
ante-natal services

Tertiary
in-patient services

- ¹ Department of Health *National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06 – 2007/08* 2004
- ² Teenage Pregnancy Unit/ Royal College of Midwives/Department of Health *Teenage Parents: Who Cares? – a guide to commissioning and delivering maternity services for young parents* February 2004
- ³ Committee for Racial Equality *Maternity services code of practice*
www.cre.gov.uk/gdpract/health_maternity_cop.html
- ⁴ Department of Health *Delivering the Best – midwives contribution to the NHS Plan* 2003 www.dh.gov.uk
- ⁵ National Institute for Clinical Excellence *Clinical Guideline Antenatal care; routine care for the healthy pregnant woman* London RCOG press October 2003
- ⁶ Singh D, Newburn M *Access to maternity information and support: the experiences and needs of women before and after giving birth* London: National Childbirth Trust 2000
- ⁷ Department of Health *Women's Mental Health: Into the Mainstream* 2002
- ⁸ Department of Health *Why Mothers Die* Report on the Confidential Enquiries into Maternal Deaths in the United Kingdom 1994-1996 London HMSO 1998
- ⁹ National Institute of Clinical Excellence *Why Mothers Die* The Confidential Enquiries into Maternal Deaths in the United Kingdom London RCOG Press 2001 ISBN 1-900364-65-4 <http://www.cemach.org.uk/publications.htm>
- ¹⁰ Department of Health *Domestic Violence: a resource manual for Healthcare Professionals* Department of Health March 2000



- ¹¹ NHS Litigation Authority *Clinical Negligence Scheme for Trusts: General – Clinical Risk Management Standards* April 2004 edition www.nhsia.com
- ¹² Disability Discrimination Act 1995 The Stationery Office 1995
- ¹³ Department of Health *Birth to Five* 2004
<http://www.publications.doh.gov.uk/birthtofive/>
- ¹⁴ SCOPE *Right From The Start Report 1994 The Template* Right from the Start Working Group 2003 edition
- ¹⁵ Department of Health *Good Practice and Innovation in Breastfeeding* Forthcoming publication 2004
- ¹⁶ Skills for Health *Children's National Workforce Competence Framework for Children's Services* April 2004 www.skillsforhealth.org.uk

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The Code

Standards of conduct, performance and ethics
for nurses and midwives

The people in your care must be able to trust you with their health and wellbeing.

To justify that trust, you must

- make the care of people your first concern, treating them as individuals and respecting their dignity
- work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community
- provide a high standard of practice and care at all times
- be open and honest, act with integrity and uphold the reputation of your profession

As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.

You must always act lawfully, whether those laws relate to your professional practice or personal life.

Failure to comply with this Code may bring your fitness to practise into question and endanger your registration.

This Code should be considered together with the Nursing and Midwifery Council's rules, standards, guidance and advice available from www.nmc-uk.org.

Make the care of people your first concern, treating them as individuals and respecting their dignity

Treat people as individuals

- You must treat people as individuals and respect their dignity
- You must not discriminate in any way against those in your care
- You must treat people kindly and considerately
- You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support

Respect people's confidentiality

- You must respect people's right to confidentiality
- You must ensure people are informed about how and why information is shared by those who will be providing their care
- You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising

Collaborate with those in your care

- You must listen to the people in your care and respond to their concerns and preferences
- You must support people in caring for themselves to improve and maintain their health
- You must recognise and respect the contribution that people make to their own care and wellbeing
- You must make arrangements to meet people's language and communication needs
- You must share with people, in a way they can understand, the information they want or need to know about their health

Ensure you gain consent

- You must ensure that you gain consent before you begin any treatment or care
- You must respect and support people's rights to accept or decline treatment and care
- You must uphold people's rights to be fully involved in decisions about their care
- You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded
- You must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency

Maintain clear professional boundaries

- You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment
- You must not ask for or accept loans from anyone in your care or anyone close to them
- You must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers

Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community

Share information with your colleagues

- You must keep your colleagues informed when you are sharing the care of others
- You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care
- You must facilitate students and others to develop their competence

Work effectively as part of a team

- You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues
- You must be willing to share your skills and experience for the benefit of your colleagues
- You must consult and take advice from colleagues when appropriate
- You must treat your colleagues fairly and without discrimination
- You must make a referral to another practitioner when it is in the best interests of someone in your care

Delegate effectively

- You must establish that anyone you delegate to is able to carry out your instructions
- You must confirm that the outcome of any delegated task meets required standards
- You must make sure that everyone you are responsible for is supervised and supported

Manage risk

- You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk
- You must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards
- You must report your concerns in writing if problems in the environment of care are putting people at risk

Provide a high standard of practice and care at all times

Use the best available evidence

- You must deliver care based on the best available evidence or best practice.
- You must ensure any advice you give is evidence based if you are suggesting healthcare products or services
- You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care

Keep your skills and knowledge up to date

- You must have the knowledge and skills for safe and effective practice when working without direct supervision
- You must recognise and work within the limits of your competence
- You must keep your knowledge and skills up to date throughout your working life
- You must take part in appropriate learning and practice activities that maintain and develop your competence and performance

Keep clear and accurate records

- You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been
- You must complete records as soon as possible after an event has occurred
- You must not tamper with original records in any way
- You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed
- You must ensure any entries you make in someone's electronic records are clearly attributable to you
- You must ensure all records are kept confidentially and securely

Be open and honest, act with integrity and uphold the reputation of your profession

Act with integrity

- You must demonstrate a personal and professional commitment to equality and diversity
- You must adhere to the laws of the country in which you are practicing
- You must inform the NMC if you have been cautioned, charged or found guilty of a criminal offence
- You must inform any employers you work for if your fitness to practice is impaired or is called into question

Deal with problems

- You must give a constructive and honest response to anyone who complains about the care they have received
- You must not allow someone's complaint to prejudice the care you provide for them
- You must act immediately to put matters right if someone in your care has suffered harm for any reason
- You must explain fully and promptly to the person affected what has happened and the likely effects
- You must cooperate with internal and external investigations

Be impartial

- You must not abuse your privileged position for your own ends
- You must ensure that your professional judgment is not influenced by any commercial considerations

Uphold the reputation of your profession

- You must not use your professional status to promote causes that are not related to health
- You must cooperate with the media only when you can confidently protect the confidential information and dignity of those in your care
- You must uphold the reputation of your profession at all times

Information about indemnity insurance

The NMC recommends that a registered nurse, midwife or specialist community public health nurse, in advising, treating and caring for patients/clients, has professional indemnity insurance. This is in the interests of clients, patients and registrants in the event of claims of professional negligence.

Whilst employers have vicarious liability for the negligent acts and/or omissions of their employees, such cover does not normally extend to activities undertaken outside the registrant's employment. Independent practice would not be covered by vicarious liability. It is the individual registrant's responsibility to establish their insurance status and take appropriate action.

In situations where an employer does not have vicarious liability, the NMC recommends that registrants obtain adequate professional indemnity insurance. If unable to secure professional indemnity insurance, a registrant will need to demonstrate that all their clients/patients are fully informed of this fact and the implications this might have in the event of a claim for professional negligence.

Contact

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www.nmc-uk.org

Healthcare professionals have a shared set of values, which find their expression in this Code for nurses and midwives. These values are also reflected in the different codes of each of the UK's healthcare regulators. This Code was approved by the NMC's Council on 6 December 2007 for implementation on 1 May 2008.

Nursing and Midwifery Council MIDWIVES RULES and STANDARDS

Introduction

The Nursing and Midwifery Council (NMC) is required by the Nursing and Midwifery Order 2001 (the Order) to establish and maintain a register of qualified nurses and midwives [Article 5(1)], and from time to time, establish standards of proficiency to be met by applicants to different parts of the register. These standards are considered necessary for safe and effective practice [Article 5(2)(a)].

The Order also requires the NMC to set rules and standards for midwifery and the Local Supervising Authorities responsible for the function of statutory supervision of midwives.

This booklet contains the rules and standards for midwifery and statutory supervision of midwives. It also provides guidance on the interpretation of those rules and standards. This replaces the previous Midwives rules and code of practice, (UKCC 1998) and standards issued by the National Boards for England, Wales, Scotland and Northern Ireland.

Establishment of the Nursing and Midwifery Council

The NMC, which was established under the Order, came into being on 1 April 2002 as the successor to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards. At that time, the Council adopted the existing rules and standards of the UKCC and, where relevant, those of the National Boards. The new rules for Education, Registration and Registration Appeals², Fees³, Midwifery⁴ and Fitness to Practise⁵ came into force on the 1 August 2004, and replace all previous rules.

The NMC rules are requirements for registration and practice that gain their authority from legislation set out in the Order. The accompanying standards describe what would reasonably be expected from someone who practises as a midwife or who is responsible for the statutory supervision of midwives.

Rule 1: Citation and commencement

Rule 2: Interpretation

Rule 3: Notification of intention to practise

1 If a midwife intends either to be in attendance upon a woman or baby during the antenatal, intranatal or postnatal period or to hold a post for which a midwifery qualification is required she shall give notice in accordance with paragraph (2).

2 A midwife shall give notice under paragraph (1) to each local supervising authority in whose area she intends to practise or continue to practise – a) before commencing to practise there; and thereafter b) in respect of each period of 12 months beginning on a date which the Council shall specify from time to time.

3 Notwithstanding the provisions of paragraph (2), the notice to be given under paragraph (1) may, in an emergency, be given after the time when she commences to practise provided that it is given within 48 hours of that time.

4 A notice to be given under this rule shall contain such particulars and be in such form as the Council may from time to time specify.

Guidance

It is your responsibility to notify your intention to practise to each local supervising authority within whose area you intend to practise midwifery, before you start practising. This will enable the local supervising authority to check that you are eligible to practise. The only exception to this is if you provide care in an emergency. In this case, the notification must be submitted to the relevant local supervising authority within a maximum of 48 hours following the emergency.

The NMC will send you a personalised intention to practise form each year if you are on the midwives' part of the register. It is your responsibility to complete the intention to practise form and return it to your named supervisor of midwives. If you do not receive a personalised form, you can obtain a blank form from your named supervisor of midwives.

If you wish to practise in a different local supervising authority, you must submit another intention to practise form to a supervisor of midwives there.

This includes looking after a friend or relative – whether or not you are paid for the attendance.

If you change your name, correspondence address or main place of work you must notify the NMC so your contact details on the database can be altered. This will enable the Council to send your intention to practise form, or other information, to your correct address for correspondence each year. The NMC will not send correspondence to your work address, as your work address is only used as a geographical indicator for the register to identify the main local supervising authority you work in.

Rule 4: Notifications by local supervising authority

1 A local supervising authority shall publish –

- a) the name and address of its midwifery officer for the submission of a notice under rule 3(1);
- b) the date by which a midwife must give notice under rule 3(1) in accordance with rule 3(2)(b).

2 Each local supervising authority shall inform the Council, in such form and at such frequency as requested by the Council, of any notice given to it under rule 3.

Guidance

You must complete, sign and return the intention to practise form to your named supervisor of midwives by the date published by the local supervising authority. Your supervisor will use this information, as well as discussion with you, to ascertain any support or development you may need to keep your practice up-to-date. They will then send the completed form to the local supervising authority midwifery officer. The information helps the local supervising authority midwifery officer to verify that only practising midwives are providing midwifery care to women and their babies in that area. The local supervising authority midwifery officer updates the local supervising authority database and forwards the information to the NMC. This enables the Council to update the register of practising midwives throughout the year. This enhances protection of the public by ensuring that midwives have met their requirements to remain on the midwives' part of the register.

Local supervising authority standards

In order to meet the statutory requirements for the supervision of midwives, a local supervising authority will:

- Publish annually the name and address of the person to whom the notice must be sent
- Publish annually the date by which it must receive intention to practise forms from midwives in its area
- Ensure accurate completion and timely delivery of intention to practise data to the NMC by the 20th of April each year.
-
- Ensure intention to practise notifications, given after the annual submission, are delivered to the NMC by the 20th of each month.

Guidance

When employers or members of the public wish to verify a midwife's registration, they will be informed if a valid intention to practise is noted on the NMC register and to which local supervising authority it applies. If one is not on record, the caller will be advised to contact the relevant local supervising authority midwifery officer to see if they have received one recently.

Rule 5 – Suspension from practice by a local supervising authority

1 Subject to the provisions of this rule a local supervising authority may, following an appropriate investigation (which is to include, where appropriate, seeking the views of the midwife concerned), suspend from practice:

- a) a midwife against whom it has reported a case for investigation to the Council, pending the outcome of the Council's investigation; or
- b) a midwife who has been referred to a Practice Committee of the Council, pending the outcome of that referral.

2 Where it exercises its power to suspend a midwife from practice, a local supervising authority shall:

- a) Immediately notify the midwife concerned in writing of the decision to suspend her and the reason for the suspension, and supply her with a copy of the documentation which it intends to submit to the Council in accordance with sub-paragraph (b); and thereafter

b) immediately report to the Council in writing any such suspension, the reason for that suspension and details of the investigation carried out by the local supervising authority that led to that suspension.

3 The Practice Committee to which the midwife concerned is referred by the Council must consider whether or not to make an interim suspension order or interim conditions of practice order in respect of the midwife concerned.

4 Unless that Practice Committee makes an interim suspension order the local supervising authority must revoke the suspension once the Committee has determined whether or not to make an interim suspension order.

5 If the Practice Committee does make an interim suspension order but that order is subsequently revoked, the local supervising authority must revoke their suspension.

Guidance

If you are concerned about a midwife's ability to practise safely and effectively you must report this to a supervisor of midwives, who will liaise closely with the local supervising authority midwifery officer. Service users, colleagues or managers may also voice such concerns. This will identify those midwives who need additional support, supervised practice, or on rare occasions, need to be suspended from practice in the interests of their or the public's safety.

Very few midwives are referred to the NMC with allegations of misconduct or incompetence. This may be as a result of supervision of midwives providing support and development of individual midwives' skills, therefore minimising the risk of poor practice developing. Anyone may refer a registrant to the Council if they are concerned about their conduct or competence. The NMC will inform you if an allegation is made against you.

If a local supervising authority is concerned about your practice, you will be informed of this and invited to be involved in their local investigation. If there is clear evidence that your practice as a midwife poses a significant risk to women or babies, or to yourself, then the local supervising authority may decide to suspend you from practice to protect the public. You will be notified in writing of the decision to suspend and this information will be sent to the NMC at the same time. Any related documents must be sent to you and the NMC immediately following the local supervising authority's decision. This suspension means you will not be able to practise as a midwife anywhere in

the UK pending a decision from the Council about the allegations against you. If you are suspended from practice by a local supervising authority, a hearing by the Interim Suspension Panel of the Investigating Committee or Health Committee is arranged to review the complaint against you. You are entitled to attend this hearing with representation should you wish, to answer questions and to give your views about the allegations. The Interim Suspension Panel can decide to uphold the suspension from practice by replacing it with an interim suspension order. If this is not the case, the local supervising authority must revoke their suspension.

A third option is to put in place a conditions of practice order which means you would be able to return to practice under certain conditions. If the local supervising authority suspension is revoked you will be able to practise again. Whatever the outcome of the Interim Suspension Panel's decision about the suspension from practice, investigations will continue into any allegations made against you until the Investigating Committee can decide whether or not there is a case to answer against you. If there is not then the case will be closed. If there is, the case will be forwarded to a panel of the Conduct and Competence Committee or the Health Committee (depending on the nature of the allegations) for a full hearing.

Anyone contacting the NMC to verify a midwife's eligibility to practise will be informed if a suspension or interim conditions of practice order is in place. There is a difference between suspension from practice and suspension from duty. If the midwife is employed within the NHS or private sector, the employer may suspend them from duty whilst management investigations take place. These are separate from any investigation the local supervising authority may undertake. Suspension from duty will only affect the midwife's employment with an organisation and they can continue to work for another employer.

Local supervising authority standards

To demonstrate there are mechanisms for the notification and investigation of allegations of a midwife's impaired fitness to practise, a local supervising authority will:

- _ Publish how it will investigate any alleged impairment of a midwife's fitness to practise

- Publish how it will determine whether or not to suspend a midwife from practice
- _ Ensure that midwives are informed in writing of the outcome of any investigation by a local supervising authority
- _ Publish the process for appeal against any decision.

Guidance

It is for an individual local supervising authority to decide what means they will use to publish their procedures. However, such publication must be easy to access by members of the public as well as registrants and healthcare providers.

Rule 6 – Responsibility and sphere of practice

- 1 A practising midwife is responsible for providing midwifery care, in accordance with such standards as the Council may specify from time to time, to a woman and baby during the antenatal, intranatal and postnatal periods.
- 2 Except in an emergency, a practising midwife shall not provide any care, or undertake any treatment, which she has not been trained to give.
- 3 In an emergency, or where a deviation from the norm which is outside her current sphere of practice becomes apparent in a woman or baby during the antenatal, intranatal or postnatal periods, a practising midwife shall call such qualified health professional as may reasonably be expected to have the necessary skills and experience to assist her in the provision of care.

Standard

A midwife:

- Cannot anyone to act as a substitute, other than another practising midwife or a registered medical practitioner
- Must make sure the needs of the woman or baby are the primary focus of her practice
- Should work in partnership with the woman and her family
- Should enable the woman to make decisions about her care based on her individual needs, by discussing matters fully with her
- Should respect the woman's right to refuse any advice given
- Is responsible for maintaining and developing her own competence
- Must ensure she becomes competent in any new skills required for her practice

- Is responsible for familiarising herself with her employer's policies.

Guidance

The Federation of International Gynaecologists and Obstetricians and the World Health Organisation's definition of the activities of a midwife determine your sphere of practice (see page 36). The conditions in which you may practise vary widely, whether in the home, in hospital or elsewhere. Your practice should be based on the best available current evidence. You are accountable for your own practice and you cannot have that accountability taken from you by another registered practitioner, nor can you give that accountability to another registered practitioner. Neither you nor your employing authority should arrange for anyone to act as a substitute for you, other than another practising midwife or a registered medical practitioner⁷.

Student midwives, student nurses and student doctors can be present, under supervision, with a woman in childbirth as part of their education. If you are supervising a student, you remain professionally accountable for what they do, including the consequences of their actions and omissions.

Guidance on clinical placements for pre-registration midwifery and nursing students is contained in An NMC guide for students of nursing and midwifery, copies of which can be downloaded, free of charge, from the Council's website at www.nmc-uk.org.

Your responsibilities, and those of other health professionals, are interrelated and complementary. Each practitioner is accountable for her own practice. Good team working is in the interests of the woman or baby and can only be achieved by mutual recognition of the respective roles of midwives and others who participate in their care. Practice must be based upon locally agreed evidence based standards to ensure that effective communication and co-operation will benefit the care of the woman and baby.

If you judge that the type of care a woman is requesting could cause significant risk to her or her baby, then you should discuss the woman's wishes with her; providing detailed information relating to her requests, options for care, and outlining any potential risks, so that the woman may make a fully informed decision about her care.

If a woman rejects your advice, you should seek further guidance from your supervisor of midwives to ensure that all possibilities have been explored and that the outcome is appropriately documented. The woman should be offered the opportunity to read what has been documented about the advice she has been given. She may sign this if she wishes. You must continue to give the best care you possibly can, seeking support from other members of the health care team as necessary. A woman is usually considered competent to make decisions about her care, but if you have any concerns about her competence to make decisions you should seek an opinion from an appropriate health professional, such as a Consultant Psychiatrist. You should be appropriately prepared and clinically up to date to ensure that you can carry out effectively, emergency procedures such as resuscitation, for the woman or baby.

Developments in midwifery care often become an integral part of the role of the midwife and may be incorporated in the initial preparation of midwives. Other developments in midwifery and obstetric practice may require that you learn new skills, but these skills do not necessarily become part of the role of all midwives. In such circumstances, each employing authority should have a locally agreed guideline, which meets the NMC standards.

It is your responsibility to determine your professional indemnity insurance status and take appropriate action. If you are unable to secure professional indemnity insurance, you must be able to demonstrate that you have kept all the women that you provide care for fully informed of this fact, and the implications this might have for them in the event of a claim against you.

Rule 7 – Administration of medicines

A practising midwife shall only supply and administer those medicines, including analgesics, in respect of which she has received the appropriate training as to use, dosage and methods of administration.

Standards

- A midwife must abide by the regulations relating to the destruction of controlled drugs
- A midwife must respect the right of individuals to self-administer substances of their choice.

Guidance

You are able to supply and administer all non-prescription medicines, which include all pharmacy and general sales list medicines without a prescription. The list of medicines are all those in the British National Formulary that are not prescription only medicines. These medicines do not need to be in a Patient Group Direction for you to be able to supply and/or administer them as part of your professional practice. Local policies, sometimes referred to as 'standing orders', have frequently been developed to supplement the legislation on medicines that practising midwives may supply and/or administer. There is no legal requirement to replace these with Patient Group Directions. You should expect your supervisor of midwives to audit your records related to drug administration from time to time. Some medicines, which are normally only available on a prescription issued by a medical practitioner, may be supplied to you for use in your practice either from a retail chemist or hospital pharmacy. Further details can be found on page 37 of this document under supplementary information and legislation.

You should advise a woman who has not used a controlled drug, which has been prescribed by her GP, to destroy it and suggest she does so in your presence. Alternatively, you can advise the woman to return the unused controlled drug to the pharmacist from where it was obtained. You must not do this for her.

Homeopathic and herbal medicines are subject to the licensing provisions of the Medicines Act 1968. A number of these however, have product licences but have not been evaluated for their efficacy, safety or quality and you should look to the best available evidence to inform women. A woman has the right to use homeopathic and herbal medicines. However, if you believe that using the medicines might be counterproductive you should discuss this with the woman.

If you are aware that a woman is self administering illegal substances you should discuss the health implications for her and her baby with her. You should also assist her by liaison with others in the multi-professional team to gain further support or access to detoxification programmes.

Rule 8 – Clinical trials

1 A practising midwife may only participate in clinical trials if there is a protocol approved by a relevant ethics committee.

2 For the purposes of this rule – “ethics committee” means an ethics committee established or recognised by the United Kingdom Ethics Committees Authority or established or recognised for the purposes of advising on the ethics of research investigations on human beings prior to 1st May 2004 by the Secretary of State, the Scottish Ministers, the National Assembly for Wales, the Department of Health, Social Services and Public Safety, a Strategic Health Authority, a Health Board, or a Health and Social Services Board.

Guidance

If you are participating in a clinical trial, you must still adhere to the Code, as well as the midwives rules and standards contained in this document. If you have any concerns about the trial, you have a duty of care to the woman and her baby and must voice those concerns to the appropriate person or authority, which may be the ethics committee.

Rule 9 – Records

1 A practising midwife shall keep, as contemporaneously as is reasonable, continuous and detailed records of observations made, care given and medicine and any form of pain relief administered by her to a woman or baby.

2 The records referred to in paragraph (1) shall be kept:

- a) in the case of a midwife employed by an NHS authority, in accordance with any directions given by her employer;
- b) in any other case, in a form approved by the local supervising authority covering her main area of practice.

3 A midwife must not destroy or permit the destruction of records which have been made whilst she is in attendance upon a woman or baby.

4 Immediately before ceasing to practise or if she finds it impossible or inconvenient to preserve her records safely, a midwife shall transfer them:

- a) if she is employed by an NHS authority, to that authority;
- b) if she is employed by a private sector employer, to that employer;
- c) if she is not covered by paragraph (a) or (b), to the local supervising authority in whose area the care took place.

5 Any transfer under paragraph (4) must be duly recorded by each party to the transfer.

6 For the purposes of this rule – “NHS authority” means a) in relation to England and Wales, any body established under the National Health Service Act 1977 or the National Health Service & Community Care Act 1990 which employs midwives;

b) in relation to Scotland, any body constituted under the National Health Service (Scotland) Act 1978 which employs midwives;

c) in relation to Northern Ireland, any body established under the Health and Personal Social Services (Northern Ireland) Order 1972 which employs midwives;

“Private sector employer” means an organisation other than an NHS authority or a limited company or partnership in which the midwife or any member of her family has or has had a substantial interest.

Guidance

Your records relating to the care of women and babies are an essential aspect of practice to aid communication between you, the woman and others who are providing care. They demonstrate whether you have provided an appropriate standard of care to a woman or baby.

General advice on record keeping is published in Guidelines for records and record keeping, which is available to download, free of charge, from the NMC website at www.nmc-uk.org. All records relating to the care of the woman or baby must be kept for 25 years. This would include work diaries if they contain clinical information. Other documents, for example, duty rotas, are a matter for local resolution and where national guidelines are available, these should be followed.

Local supervising authority standards

To ensure the safe preservation of records transferred to it in accordance with the Midwives rules 8, a local supervising authority will:

- Publish local procedures for the transfer of midwifery records from self employed midwives
- Agree local systems to ensure supervisors of midwives maintain records of their supervisory activity

- Ensure supervisors of midwives records, relating to the statutory supervision of midwives, are kept for a minimum of seven years
- Arrange for supervision records relating to an investigation of a clinical incident to be kept for a minimum of 25 years
- Publish local procedures for retention and transfer of records relating to statutory supervision.

Guidance

The majority of supervisors' records relate to information such as continuing professional development and support. They could be regarded as personnel files and should be kept for seven years. A copy of these records can also be given to the midwife. Any supervisory records relating to investigation of a clinical incident, alleged misconduct or incompetence relating to a midwife must be kept for 25 years.

Rule 10 – Inspection of premises and equipment

1 A practising midwife shall give to a supervisor of midwives, a local supervising authority and the Council, every reasonable facility to monitor her standards and methods of practice and to inspect her records, her equipment and any premises that she is entitled to permit them to enter, which may include such part of the midwife's residence as may be used for professional purposes.

2 A practising midwife shall use her best endeavours to permit inspection from time to time of all places of work in which she practises, other than the private residence of a woman and baby she is attending, by persons nominated by the Council for this purpose, one of whom shall be a practising midwife.

Guidance

It is your responsibility to let the local supervising authority and the NMC monitor your standards and methods of practice. This may include allowing access to your records, equipment and place of work.

Rule 11 – Eligibility for appointment as a supervisor of midwives

1 A local supervising authority shall appoint an adequate number of supervisors of midwives to exercise supervision over practising midwives in its area.

2 To be appointed for the first time as a supervisor of midwives, in accordance with article 43(2) of the Order, a person shall - a) be a practising midwife; b) have three years' experience as a practising midwife of which at least one shall have been in the two year period immediately preceding the appointment; and c) have successfully completed a programme of a type mentioned in paragraph (5) within the three year period prior to her first appointment as a supervisor of midwives.

3 For any subsequent appointment as a supervisor of midwives, a person must have practised in such a role for three years within the five year period prior to new appointment.

4 In the case of a national of an EEA state (or other person entitled to be treated for the purpose of appointment as a supervisor of midwives, no less favourably than a national of such a state by virtue of an enforceable community law right or any enactment giving effect to a community obligation) the conditions in paragraph (2) or (3) shall be satisfied if, in the opinion of the Council, a person has had comparable training or experience within or outside the EEA.

5 The provider, content and duration of a programme referred to in paragraph (2)(c) shall be such as the Council shall from time to time specify for the purposes of this rule.

6 Following her appointment, a supervisor of midwives shall complete such periods of study relating to the supervision of midwives as the Council shall from time to time require.

Local supervising authority standard

In order to ensure that supervisors of midwives meet the requirements of Rule 11 (see above) a local supervising authority will:

- Publish their policy for the appointment of any new supervisor of midwives in their area
- Maintain a current list of supervisors of midwives

- Demonstrate a commitment to providing continuing professional development and updating for all supervisors of midwives for a minimum of 15 hours in each registration period.

Guidance

The role of a supervisor of midwives is to protect the public by empowering midwives and midwifery students to practise safely and effectively. Supervisors are accountable to the local supervising authority for all supervisory activities. When midwives are faced with a situation where they feel they need support and advice the supervisor acts as a resource. Supervisors can also assist in discussions with women when concerns are expressed regarding the provision of care.

The success of supervision reflects the ability of those who do it and it is, therefore, important to get the right person into the role. To become a supervisor of midwives, a midwife will need to go through a selection process set by the local supervising authority, which meets the standards set by the NMC.

Successful completion of the preparation course for supervisors does not mean that the midwife automatically becomes a supervisor, as she has to be appointed by the local supervising authority to undertake the role. It is only at this point that a midwife can be called a supervisor of midwives.

Once in the role, supervisors will be required to update their knowledge and skills in relation to supervision in addition to any updates required to maintain their midwifery registration.

Rule 12 – The supervision of midwives

1 Each practising midwife shall have a named supervisor of midwives from among the supervisors of midwives appointed by the local supervising authority covering her main area of practice.

2 A local supervising authority shall ensure that:

- a) each practising midwife within its area has a named supervisor of midwives;
- b) at least once a year, each supervisor of midwives meets each midwife for whom she is the named supervisor of midwives to review the midwife's practice and to identify her training needs;

- c) all supervisors of midwives within its area maintain records of their supervisory activities, including any meeting with a midwife; and
- d) all practising midwives within its area have 24-hour access to a supervisor of midwives.

Guidance

Having a named supervisor of midwives means you will know who your supervisor is and she can offer continuity of support for you. This supervisor will be from the local supervising authority covering your main area of practise and can, if needed, liaise with other supervisors if you practise outside that area.

You can also expect a supervisor to be available to you at all times for advice and guidance in each local supervising authority that you practise in. This need not be your named supervisor nor be from the organisation you are working in. It is for each local supervising authority to determine how 24-hour access to a supervisor of midwives for advice and support is organised.

You should be able to choose your supervisor if you know them or one will be allocated to you by the local supervising authority if you do not. If the relationship is not beneficial to you both, either of you can request to change. You should arrange to meet with your supervisor at least once a year for the purpose of statutory supervision. This provides you with the opportunity to discuss your personal and professional development. An agreed record of any meeting will assist in continuity of support for you.

Although these records are confidential between you and your supervisor it is important for you to understand that in certain circumstances, they may be disclosed, for example, in a local supervising authority or NMC fitness to practice investigation. In other circumstances, a court order would be required before the disclosure of these records. If you move area or change your supervisor, your supervisory records should be transferred to your new supervisor of midwives.

Local supervising authority standard

To ensure that a local framework exists to provide equitable, effective supervision for all midwives working within the local supervising authority, and

that a supervisor of midwives is accessible at all times a local supervising authority will:

- Publish the local mechanism for confirming any midwife's eligibility to practise
- Implement the NMC's rules and standards for supervision of midwives
- Ensure that the supervisor of midwives to midwives ratio reflects local need and circumstances (will not normally exceed 1:15)
- Enable student midwives to be supported by the supervisory framework.
- To ensure a communications network, which facilitates ease of contact and the distribution of information between all supervisors of midwives and other local supervising authorities, a local supervising authority will:
 - Set up systems to facilitate communication links between and across local supervising authority boundaries
 - Enable timely distribution of information to all supervisors of midwives
 - Provide a direct communication link, which may be electronic, between each supervisor of midwives and the local supervising authority midwifery officer
 - Provide for the local supervising authority midwifery officer to have regular meetings with supervisors of midwives to give support and agree strategies for developing key areas of practice.

To ensure there is support for the supervision of midwives the local supervising authority will:

- Monitor the provision of protected time and administrative support for supervisors of midwives
- Promote woman-centred, evidenced-based midwifery practice
- Ensure that supervisors of midwives maintain accurate data and records of all their supervisory activities and meetings with the midwives they supervise.

A local supervising authority shall set standards for supervisors of midwives that incorporate the following broad principles:

- Supervisors of midwives are available to offer guidance and support to women accessing maternity services

- Supervisors of midwives give advice and guidance regarding women centred care and promote evidence-based midwifery practice
- Supervisors of midwives are directly accountable to the local supervising authority for all matters relating to the statutory supervision of midwives
- Supervisors of midwives provide professional leadership
- Supervisors of midwives are approachable and accessible to midwives to support them in their practice.

Guidance

To maximise the effectiveness of supervision of midwives, resources must be made available for this activity. A local supervising authority needs to monitor that the number of supervisors of midwives and the resources made available to them is sufficient. Regular meetings between supervisors and the local supervising authority midwifery officer ensure up-to-date information is exchanged, thereby giving opportunity for discussion to provide advice and support.

Rule 13 – The local supervising authority midwifery officer

1 Each local supervising authority shall appoint a local supervising authority midwifery officer who shall be responsible for exercising its functions in relation to the supervision of midwives including in relation to the appointment of supervisors of midwives under rule 11(1).

2 A local supervising authority shall not appoint a person to the post of local supervising authority midwifery officer unless:

- a) she is a practising midwife; and
- b) she meets the standards of experience and education set by the Council from time to time.

Local supervising authority standard

In order to discharge the local supervising authority supervisory function in its area through the local supervising authority midwifery officer, the local supervising authority will:

- Use the NMC core criteria and person specification when appointing a local supervising authority midwifery officer

- Involve a NMC nominated and appropriately experienced midwife in the selection and appointment process
- Manage the performance of the appointed local supervising authority midwifery officer
- Provide designated time and administrative support for a local supervising authority midwifery officer to discharge the statutory supervisory function
- Arrange for the local supervising authority midwifery officer to complete an annual audit of the practice and supervision of midwives within its area to ensure the requirements of the NMC are being met.

Guidance

The local supervising authority sits within a NHS authority and the local supervising authority midwifery officer is subject to the terms and conditions of that employment. The type of NHS authority will vary in each country of the UK. The NMC issues core standards for appointments to these posts in the form of NMC Circulars, as requirements for these posts may change over time. Copies of these can be obtained free of charge from the NMC website at www.nmc-uk.org.

Good communication between the local supervising authority and the Council will enhance protection of the public, especially if there are any concerns relating to the function of midwifery supervision or midwifery practice.

Women should be able to access the local supervising authority midwifery officer directly if they wish to discuss any aspect of their care that they do not feel has been addressed through other channels.

The local supervising authority midwifery officer plays a pivotal role in clinical governance by ensuring the standard of supervision of midwives and midwifery practice meets that required by the NMC. She is expected to promote openness and transparency in exercising supervision over midwives and the role is impartial in that it does not represent the interests of any health service provider.

To inform the local supervising authority annual report, the local supervising authority midwifery officer will undertake an audit of maternity units within the

area. This process should include input from service users to assess whether or not the midwifery care being provided is women-centred.

Rule 14 – Exercise by a local supervising authority of its functions

Where a local supervising authority (in relation to the exercise of its functions as to the supervision of midwives) has concerns about whether a local supervising authority midwifery officer or a supervisor of midwives meets the Council's standards, it shall discuss those concerns with the Council.

Guidance

Where the competence of a local supervising authority midwifery officer or a supervisor of midwives to undertake the role is in question, or allegations have been made against them, the local supervising authority will investigate, in accordance with their employment processes. The local supervising authority is able to use the NMC as a resource in helping them to manage a variety of situations related to professional concerns.

Rule 15 – Publication of local supervising authority procedures

Each local supervising authority shall publish:

- a) the name and address of its midwifery officer, together with the procedure for reporting all adverse incidents relating to midwifery practice or allegations of impaired fitness to practise of practising midwives within its area and the procedure by which it will investigate any such reports;
- b) the procedure by which it will deal with complaints or allegations against its midwifery officer or supervisor of midwives within its area.

Local supervising authority standard

To ensure incidents that cause serious concern in its area relating to maternity care or midwifery practice are notified to the local supervising authority midwifery officer, a local supervising authority will:

- Develop mechanisms with NHS authorities and private sector employers to ensure that a local supervising authority midwifery officer is notified of all such incidents
- Publish the investigative procedure
- Liaise with key stakeholders to enhance clinical governance systems.

To confirm the mechanisms for the notification and management of poor performance of a local supervising authority midwifery officer or supervisor of midwives, the local supervising authority will:

- Publish the process for the notification and management of complaints against any local supervising authority midwifery officer or supervisor of midwives
- Publish the process for removing a local supervising authority midwifery officer or supervisor of midwives from appointment
- Publish the process for appeal against the decision to remove
- Ensure that a local supervising authority midwifery officer or supervisor of midwives is informed of the outcome of any local supervising authority investigation of poor performance, following its completion
- Consult the NMC for advice and guidance in such matters.

Guidance

Supervision of midwives is about the midwives themselves, the care they give and where they give it. It is important that a local supervising authority midwifery officer is aware of incidents, within a maternity service, where actual or potential harm has occurred to a woman and/or her baby when midwifery practice is involved. The service should inform the local supervising authority midwifery officer who will decide the course of action to take. Much can be learned from such incidents and the local supervising authority midwifery officer is well placed to suggest changes in practice or how best to support a midwife whose practise has fallen below the expected standard.

If a local supervising authority midwifery officer or supervisor of midwives fails to carry out their role or maintain the standards expected of them, there should be an open and transparent process for this to be reported and managed. Service users, midwives, supervisors of midwives and employers should be able to access published details of how, when, why and to whom to make a complaint. In fairness to the individuals concerned, there needs to be an open and transparent process dealing with such allegations, which includes an appeal process.

Rule 16 – Annual report

Each year every local supervising authority shall submit a written report to the Council by such date and containing such information as the Council may specify.

Local supervising authority standard

A written, annual local supervising authority report will reach the Midwifery Committee of the NMC, in a form agreed by the Nursing and Midwifery Council, by the 1st of June each year. Each local supervising authority will ensure their report is made available to the public.

- The report will include but not necessarily be limited to:
- Numbers of supervisor of midwives appointments, resignations and removals
- Details of how midwives are provided with continuous access to a supervisor of midwives
- Details of how the practice of midwifery is supervised
- Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits
- Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education
- Details of any new policies related to the supervision of midwives
- Evidence of developing trends affecting midwifery practice in the local supervising authority
- Details of the number of complaints regarding the discharge of the supervisory function
- Reports on all local supervising authority investigations undertaken during the year.

Guidance

The NMC has a duty to monitor that the local supervising authorities are meeting the required standards. The annual local supervising authority report will help the Council to do this, and it is one opportunity for a local supervising authority to inform the NMC and the public about activities, key issues, good practice and trends affecting maternity services within its area.

Another opportunity will be through the NMC visits to local supervising authorities, which will occur on a regular basis.

Supplementary information and legislation

The International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO) first adopted the formal definition of a midwife in 1972 and 1973 respectively. The World Health Organisation (WHO) has also adopted it. The definition was amended by the ICM in 1990 and the FIGO and the WHO then ratified this amendment in 1991 and 1992 respectively. The definition states:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

Extract from the EU Second Midwifery Directive 80/155/EEC Article 4 – activities of a midwife

Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:

- To provide sound family planning information and advice
- To diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk

- To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
- To care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means
- To conduct spontaneous deliveries including where required an episiotomy and, in urgent cases, a breech delivery
- To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus
- To examine and care for the new born infant: to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation
- To care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new born infant
- To carry out treatment prescribed by a doctor
- To maintain all necessary records.

Legislation with regard to the supply and administration of medicines

Registered midwives are able to supply and administer, as appropriate, on their own initiative and as part of their professional practice certain medicinal products covered by legal "exemptions". The relevant pieces of legislation are as follows.

For pharmacy and general sales list medicines

The Medicines (Pharmacy and General Sale – Exemption) Order 1980 (SI 1980/1924) deals with Pharmacy and General Sale List exemptions as follows:

Exemption for products used by midwives in the course of their professional practice.

4. There are hereby specified for the purposes of section 55(2)(b) (exemptions for

certified midwives) the following classes of medicinal products:

(a) all medicinal products that are not prescription only medicines, and

(b) prescription only medicines which, by virtue of an exemption conferred by an order made under section 58(4)(a), may be sold or supplied by a certified midwife otherwise than in accordance with a prescription given by a practitioner.

For prescription only medicines (POMs)

The Prescription Only Medicines (Human Use) Order 1997 (SI 1997/1830). The two relevant exemptions from the POM Order are contained in Schedule 5; Article 11(1)(a) Part I covers exemptions from restrictions on the sale and supply, and Article 11(2) Part III covers exemptions from the restrictions on administration of prescription only medicines.

Congenital Disabilities (Civil Liability) Act 1976

This act applies in England, Wales and Northern Ireland and provides for a child to recover damages where he or she has suffered as a result of a breach in a duty of care owed to the mother or the father, unless that breach of duty of care occurred before the child was conceived and either or both parents knew of the occurrence.

Therefore, the retention of records relating to childbirth is particularly important and no midwife should destroy such records. Copies of the Act are available from The Stationery Office, (www.hmsso.gov.uk).

In Scotland, the Scottish Law Commission's report, Liability for antenatal injury, stresses that existing law and precedents in Scotland make the same provisions as those in Data Protection Act 1998

This applies to the whole of the United Kingdom and seeks to ensure that confidential information held about individuals is protected in law. The Act came into force on 1 March 2000 and implements EU Data Protection Directive 95/46/EC. It sets rules for processing personal information and applies to paper records as well as those held on computers. The eight Data Protection Principles say that data must be: fairly and lawfully processed; processed for limited purposes; adequate relevant and not excessive; accurate; not kept longer than necessary; processed in accordance with people's rights; secure; and not transferred to other countries without adequate protection.

The Act gives individuals (data subjects) the right to gain access to personal data about themselves, including health information. The Act applies only to living individuals and replaces the Data Protection Act 1984.

Access to Health Records Act 1990

The Access to Health Records Act 1990 has been repealed, except for the sections dealing with requests for access to records relating to the deceased. Requests for access to health records relating to living individuals, whether manual or automated, will now fall within the scope of the subject access provisions of Data Protection Act 1998.

Further information and advice is available in the Guidelines for records and record keeping (NMC 2002) which is available for downloading free of charge from the NMC website on www.nmc-uk.org.

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides for a general right of access to information held by public authorities, or by those providing services for public authorities and comes into force on 1 January 2005. A "public authority" is defined in the Act. It applies to public authorities in England, Wales and Northern Ireland. Scotland has its own Freedom of Information (Scotland) Act 2002. The Scottish Act applies to public authorities which are carrying out functions devolved to the Scottish Executive.

August 2004



St Thomas' Hospital Research Ethics Committee

Telephone: 0207 188 2257
Facsimile: 0207 188 2258

Email: maureen.fisher@gstt.sthames.nhs.uk

05 January 2005

Mrs Alison Herron
Queen Elizabeth Hospital NHS TRUST
Stadium Road
Woolwich
LONDON
SE184QH

Dear Mrs Herron

Full title of study: MIDWIFERY AND AUTONOMY
REC reference number: 04/Q0702/131

Thank you for your letter of 21 December 2004, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application		01/11/2004	08/11/2004
Investigator CV			08/11/2004
Protocol	1	05/11/2004	08/11/2004
Participant Information Sheet	2	14/12/2004	05/01/2005
Participant Consent Form	2	14/12/2004	05/01/2005

SL14 Favourable opinion following consideration of further information
Version 2, October 2004

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

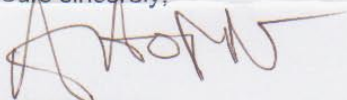
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q0702/131

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,



Dr A Hopper
Chair

E-mail: maureen.fisher@gstt.sthames.nhs.uk

Enclosures List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Site approval form (SF1)

Copy to R & D

Enclosure 3

St Thomas' Hospital Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	04/Q0702/131	Issue number:	1	Date of issue:	05 January 2005
Chief Investigator:	MRS ALISON J HERRON				
Full title of study:	MIDWIFERY AND AUTONOMY				

This study was given a favourable ethical opinion by St Thomas' Hospital Research Ethics Committee on 05 January 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

An advisory committee to South East London Strategic Health Authority

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes ⁽¹⁾
Single Site application N/A	Single Site application N/A	St Thomas' Hospital Maternity Unit, Birth Centre	St Thomas' Hospital Research Ethics Committee	05/01/2005	
Approved by the Chair on behalf of the REC: (Signature of Chair/Administrator*) (*delete as applicable) (Name)					

⁽¹⁾ The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.



Mrs Alison Herron
16 Hastings Street
The Royal Arsenal
Woolwich
LONDON
SE184QH

13 September 2005

**ST THOMAS' HOSPITAL
RESEARCH ETHICS COMMITTEE**

*Ethics Committee Office
Block 5, South Wing,
St Thomas' Hospital
London SE1 7EH*

**Chairman – Dr A Hopper/Dr AJ Williams
Administrator – Ms S Hirsch**

Phone: 020 7188 2257 (direct line)
Fax: 020 7188 2258
Email: Stella.hirsch@gstt.sthames.nhs.uk

Dear Mrs Herron

**Full title of study: MIDWIFERY AND AUTONOMY
REC reference number: 04/Q0702/131**

The REC gave a favourable ethical opinion to this study on 05 January 2005.

Further notification(s) have been received from local site assessor(s) following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site(s). I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research.

Management approval

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until management approval from the relevant NHS care organisation has been confirmed.

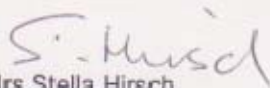
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q0702/131

Please quote this number on all correspondence

Yours sincerely


Mrs Stella Hirsch
Administrator

Enclosure: List of Sites with Favourable Ethical Opinion - Site approval form (SF1)
Copy to R & D

St Thomas' Hospital Research Ethics Committee				
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION				
For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.				
REC reference number:	04/Q0702/131	Issue number:	2	Date of issue:
Chief Investigator:	MRS ALISON J HERRON			
Full title of study:	MIDWIFERY AND AUTONOMY			
This study was given a favourable ethical opinion by St Thomas' Hospital Research Ethics Committee on 05 January 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.				
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site
Mrs Alison Herron		St Thomas Hospital, Maternity Unit, Birth Centre	St Thomas' Hospital Research Ethics Committee	05/01/2005
Mrs. Alison J. Herron	Independent Midwife and Bank Midwife	Crowborough Birthing Centre, East Sussex Hospitals NHS Trust	East Sussex Local Research Ethics Committee	13/09/2005
Approved by the Chair on behalf of the REC:				
<div style="display: flex; justify-content: space-between;"> <div> <i>S. Herron</i> (delete as applicable) </div> <div> (Signature of Chair/Administrator) </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div> <i>S. Herron</i> </div> <div> (Name) </div> </div>				

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

SF1 List of approved sites

What will happen to the results of the research study?

I will make sure that all the information is stored safely and no one except myself as the researcher will have access to it. I will be analysing the data collected from the interviews and on completion of the project I will inform all participants of the results. I expect the study to take two years to complete but preliminary findings can be obtained by contacting me.

Who has reviewed the study?

Ethical approval has been obtained from the health studies ethics sub-committee at Middlesex University and consent from the Director of Midwifery and Trust Research and Development Officer has been given to undertake interviews within each hospital.

Contact for further information

Name of Lead Researcher:

Alison Herron

Address: **16 Hastings Street,
The royal Arsenal
Woolwich,
London.
SE18 6SY**

Telephone No: **020 8309 8561**

Email:
ali@87bow.freemove.co.uk



RESEARCH CENTRE FOR
TRANSCULTURAL
STUDIES IN HEALTH

Autonomy and Midwifery

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish before you agree to take part. You can get further information by contacting me (see the back of this leaflet for contact details).

Thank you for reading this.

What is the purpose of this study?

I am currently working as an Independent midwife in East London and am undertaking this research as part of my study for

MPhil. I am trying to find out midwives understanding of autonomy and if autonomy is affected by factors guiding midwifery practice like the Scope of Practice, Supervision and Accountability within different working environments.

Why have I been chosen?

I am interviewing 25 midwives within the Independent and NHS sector with varying degrees of experience and within five main models of midwifery care: independent, hospital based, integrated birth centre, free standing birth centre and community. The interviews being conducted with five midwives from each group.

Do I have to Take Part?

It is up to you to decide whether to participate. If you decide to take part you will be given this information sheet to keep and be

asked to sign a consent form. If at some point you wish to withdraw you are free to do so without giving a reason. This decision to withdraw at any time, or a decision not to take part, will not affect your employment.

What will happen to me if I take part?

I am utilising survey methods for collecting information to answer the research question through the use of interviews.

You will be asked to attend one interview with myself at a convenient time and place to suit you.

The interview will take approximately one hour and will be to discuss autonomy as explained within the purpose of this study.

What are the possible disadvantages and risks of taking part?

None that I know of, but if you have any concerns please raise

them with me and I will endeavour to clarify them.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you, which is used, will have your name removed so that you cannot be recognised from it. Audiotapes will be used for the interviews with your consent. The tapes will not include your name and will be erased once they are no longer required for the research.

You will be offered a copy of the tape at the end of the interview.

CONSENT FORM



Title of Project: Autonomy and Midwifery

Name of Researcher: Alison Herron

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that my name will not be used within the research and that I can request a copy of any tape used within the interview and that the tape will be erased when no longer required by the researcher.
4. I agree to take part in the above study.

Name of Midwife

Date

Signature

Researcher

Date

Signature

Autonomy and Midwifery - Aide Memoir for Interview

The purpose of the study

I am currently working as an Independent midwife in East London and am undertaking this research as part of my study for MPhil. I am trying to find out midwives understanding of autonomy and if autonomy is affected by factors guiding midwifery practice like the Scope of Practice, Supervision and Accountability within different working environments.

Q1 Why did you choose midwifery as a career?

Looking for personal values Look for personal philosophy of care Personal characteristics attributing to autonomy

Q2 How did your training prepare you for your role as a midwife?

Type of training How long qualified Look for factors of education making impact on midwifery role and autonomy
--

Q3 What areas of midwifery practice have you worked in since qualifying?

Look at type of experience Looking for impact on the value of autonomy

Q4 What are the main aspects of your role today?

Experience Client group. Look for cultural issues affecting decision-making Look for factors which affect autonomy
--

Q5 What does autonomy mean to you?

Looking for personal and professional definition including accountability
Try and get them to use first person 'I' throughout the interview
Impact of NMC guidelines (Scope of Practice)

Q6 How do you believe the working environment affects your practice?

Facilities available
Other professionals-help or hinder
Local policy
Complaints/Fear of litigation

Q7 How would you describe the support you get in your professional role?

Look for factors which contribute to autonomy
Look for impact of supervision
Look for managerial versus clinical support

Q8 What are your midwifery plans for the future?

Look for job satisfaction
Look for correlation between value of autonomy and retention of staff

Q9 Any further comments/suggestions which may be useful for this study.

Thank You

ALI HERRON
INDEPENDENT MIDWIFE
16, HASTINGS STREET
THE ROYAL ARSENAL
WOOLWICH
LONDON
SE18 6SY

Home Phone 0208
3098561

03rd October 2007

Dear

I hope this letter finds you well. I would like to thank you again for participating as an interviewee with my research on Autonomy and Midwifery. I am now at the final stages of my analysis but before I proceed further I would appreciate your assistance in verifying or otherwise the themes I have identified from the transcribed interview tapes.

I am enclosing a flow chart of the themes and sub-themes with memo explanation for these. I would be very grateful if you could find the time to look at them and then inform me as to the accuracy of my findings. I need to be assured or not that:

1. The thematic findings are an accurate basis of what you discussed with me regarding autonomy during the interview.
2. I have not omitted, misrepresented or misinterpreted your responses.
3. The points and issues raised were recognised and are valuable to the study.

Your viewpoint on these three questions and any other comments you wish to add can be sent to me either in writing to the above address or via email: ali@87bow.freemove.co.uk .

I look forward to hearing from you soon and thank you in advance for your assistance.

Kind Regards,

Alison Herron. RGN, RM, ITEC

AUTONOMY AND MIDWIFERY

Memos for themes and sub-themes

The Impact of Hierarchy on Midwifery Practice

This explores the impact and relationship of the hierarchical structure within maternity services on midwifery practice. In particular the relevance to the culture of the working environment, the trust of colleagues and the importance of negotiation within practice.

The Advantage or Disadvantage of Rules and Policies on Clinical Practice

Rules and policies are a base for midwifery practice. This theme concentrates on their advantages and disadvantages as perceived by midwives within the realms of safety and flexibility. It also looks at the relationship with risk management and how this impacts on autonomy.

The Perception of the Characteristics of an Autonomous Practitioner

This looks at how midwives perceive an autonomous practitioner with regard to their traits and specific knowledge and the control a midwife has within their working practice.

The Effect of the Relationship between Midwives and the Women, their Colleagues and Employers

This theme concentrates on the affect of women's autonomy on midwifery practice and how differing relationships between colleagues and employers can impact on midwives autonomy.

How the Potential for Role Confusion between Statutory Supervision and Management of Midwives impacts on Midwifery Practice

This theme discusses the impact of supervision versus management of midwifery practice with particular relevance to support or restriction of practice as well as the aspect of self development and how all of these are related to midwifery autonomy.

How Fear Impacts on Midwifery Practice

What makes midwives fearful, including anxiety, and affects their daily practice from the aspects of employment and litigation. It also looks at the relationship between confidence and competence on the fear of autonomy.

What Defines the Freedom to Practice Autonomously?

This theme discusses the aspects of midwifery practice that allow or disallow midwives to practice autonomously with regard to protocols, practice area and decision-making skills. It also covers the impact of work systems like the NHS and Private Practice on freedom of autonomous practice.

How Midwives Measure Autonomy within the Work Environment

This theme covers aspects of a midwife's practice that are then used by them to measure the extent of their own autonomy. It involves their experience of and type of professional education as well as their experience through their midwifery career. It looks at their accountability and the link with autonomy and how guidelines within their working area can affect the extent to which they practice autonomy.